No. 14-723

Title:	Robert Montanile, Petitioner v. Board of Trustees of the National Elevator Industry Health Benefit Plan
Docketed:	December 19, 2014
Lower Ct:	United States Court of Appeals for the Eleventh Circuit
Case Nos.:	(14-11678)
Decision Date:	November 25, 2014

Questions Presented

---Date---	------Proceedings and Orders----------
Dec 16 2014	Petition for a writ of certiorari filed. (Response due January 20, 2015)
Dec 29 2014	Order extending time to file response to petition to and including February 19, 2015.
Feb 19 2015	Brief of respondent Board of Trustees of the National Elevator Industry Health Benefit Plan in filed.
Feb 25 2015	Letter from counsel for petitioner received waiving the 14-day waiting period for the filing of a reply brief pursuant to Rule 15.5.
Feb 25 2015	DISTRIBUTED for Conference of March 20, 2015.
Mar 23 2015	DISTRIBUTED for Conference of March 27, 2015.
Mar 30 2015	Petition GRANTED.
Apr 20 2015	The time to file the joint appendix and petitioner's brief on the merits is extended to and including July 6, 2015.
Apr 20 2015	The time to file respondent's brief on the merits is extended to and including September 25, 2015.
Jun 3 2015	Consent to the filing of amicus curiae briefs, in support of either party or of neither party received from counsel for the respondent.
Jun 3 2015	Consent to the filing of amicus curiae briefs in support of either party or of neither party received from counsel for the petitioner.
Jul 6 2015	Joint appendix filed. (Statement of costs filed.)
Jul 6 2015	Brief of petitioner Robert Montanile filed.
Jul 13 2015	Brief amicus curiae of United States filed.
Jul 13 2015	Brief amicus curiae of United Policyholders filed.
Jul 13 2015	Brief amicus curiae of AARP filed.
Jul 13 2015	Brief amicus curiae of The American Association for Justice filed.
Sep 9 2015	SET FOR ARGUMENT on Monday, November 9, 2015.
Sep 10 2015	Record requested from the U.S.C.A. 11th Circuit.
Sep 25 2015	Brief of respondent Board of Trustees of ...e National Elevator Industry Health Benefit Plan filed.
Sep 29 2015	CIRCULATED.
Oct 2 2015	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae

	and for divided argument filed.
Oct 2 2015	Brief amici curiae of National Association of Subrogation Professionals, et al. filed. (Distributed)
Oct 2 2015	Brief amici curiae of IBEW-NECA Southwestern Health & Benefit Fund, et al. filed. (Distributed)
Oct 2 2015	Brief amicus curiae of National Coordinating Committee for Multiemployer Plans filed. (Distributed)
Oct 26 2015	Reply of petitioner Robert Montanile filed. (Distributed)
Oct 30 2015	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
Nov 9 2015	Argued. For petitioner: Peter K. Stris, Los Angeles, Cal., and Ginger D. Anders, Assistant to the Solicitor General, Department of Justice, Washington, D. C. (for United States, as amicus curiae.) For respondent: Neal K. Katyal, Washington, D. C.

14-723

No. ___

IN THE

Supreme Court of the United States

ROBERT MONTANILE,

Petitioner,

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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December 16, 2014

QUESTION PRESENTED

This petition presents a single question about the meaning of an important remedial provision of the Employee Retirement and Income Security Act of 1974 ("ERISA"). Eight of the thirteen circuits have squarely and openly disagreed over the question presented. The result is a widely acknowledged 6-2 circuit split. In a recent invitation brief, the United States acknowledged the (then) 5-2 circuit split and endorsed the *minority* position. Brief for the United States as Amicus Curiae, Thurber v. Aetna Life Ins. Co., 134 S.Ct. 2723 (May 6, 2014) (No. 13-130). The government recommended denial, however, solely on vehicle grounds. *Id.* at 15–20. The petition was denied.

The question presented by this petition is:

Does a lawsuit by an ERISA fiduciary against a participant to recover an alleged overpayment by the plan seek "equitable relief" within the meaning of ERISA section 502(a)(3), 29 U.S.C. § 1132(a)(3), if the fiduciary has not identified a particular fund that is in the participant's possession and control at the time the fiduciary asserts its claim?

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INTRODUCTION

There is a well-recognized and intractable circuit split involving eight of the thirteen circuits over the question presented. *See infra* 15–17. Certiorari is warranted for that reason alone. Sup. Ct. R. 10(a).

But the question presented is worthy of review for other reasons as well. It turns entirely on the proper interpretation of this Court's line of ERISA section 502(a)(3) cases. Six circuits read those cases one way. Two circuits, joined by the United States Solicitor General and the United States Department of Labor, read those cases to mean precisely the opposite. Thus, one group of circuits has *necessarily* decided "an important federal question in a way that conflicts with relevant decisions of this Court." Sup. Ct. R. 10(c). And for precisely the reasons articulated by the United States in a recent invitation brief, the decision below is on the wrong side of that conflict. *See infra* 17–18 (discussing Brief for the United States as Amicus Curiae, Thurber v. Aetna Life Ins. Co., 134 S.Ct. 2723 (May 6, 2014) (No. 13-130) ("U.S. Br."); *see also infra* 3–6 (discussing this Court's prior ERISA section 502(a)(3) cases).

The time for resolution is now. As leading advocates on both sides of this issue have made clear, the question presented is of extraordinary importance to employers and workers across the country and requires a uniform national answer. *See infra* 18–22. And, unlike in *Thurber*, there is no "logically antecedent issue" or other vehicle problem in this case that "could prevent the Court from deciding the . . . question presented." U.S. Br. 5.

The petition should be granted.

OPINIONS BELOW

The opinion of the Eleventh Circuit in this case (Pet. App. 1–18) is unreported. The district court's summary-judgment decision (Pet. App. 19–45) is unreported. The 2-1 decision of the Eleventh Circuit in *AirTran Airways, Inc. v. Elem*, by which the panel in this case was bound, (Pet. App. 46–76) is reported at 767 F.3d 1192. The order denying rehearing and rehearing *en banc* in *AirTran* (Pet. App. 77–78) is unreported.[1]

JURISDICTION

The judgment of the court of appeals was entered on November 25, 2014. Pet. App. 1. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

Section 502 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132, as amended, provides in relevant part:

> (a) Persons empowered to bring a civil action.
>
> A civil action may be brought—
>
> ***
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to

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[1] For the convenience of the Court, Petitioner has reproduced in the Appendix the two relevant *AirTran* decisions.

redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

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STATEMENT OF THE CASE

This petition presents a single question about the meaning of an important remedial provision of ERISA. That statutory provision, which has already resulted in several published decisions by this Court, authorizes a participant, beneficiary, or fiduciary to obtain an injunction or "other appropriate equitable relief" to redress statutory violations or to enforce the terms of an ERISA plan. 29 U.S.C. § 1132(a)(3).

In an effort to clearly explain the need for further review, this petition first provides some necessary statutory and factual background. It then recounts the relevant procedural history of this case.

A. Statutory Background

ERISA is a landmark federal statute designed "to promote the interests of employees and their beneficiaries in employee benefit plans." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (citations omitted). It was drafted to include not only pension plans, 29 U.S.C. § 1002(2), but also welfare plans, 29 U.S.C. § 1002(1). Today, ERISA welfare plans are the primary source of health, life, and disability insurance for millions of Americans.

Section 502(a) of ERISA sets forth the exclusive remedies that are available to a civil litigant under the statute. *See* 29 U.S.C. § 1132(a). The most controversial part of ERISA's remedies provisions is section

502(a)(3)(B), which authorizes a civil action to recover "appropriate equitable relief." 29 U.S.C. § 1132(a)(3)(B).[2] That statutory phrase has already resulted in several decisions by this Court:

1. In 1993, this Court first interpreted the meaning of the words "appropriate equitable relief" in 29 U.S.C. § 1132(a)(3)(B). *See Mertens v. Hewitt*, 508 U.S. 248 (1993). In a 5-4 decision, the *Mertens* Court held that Congress intended the phrase to refer only to "those categories of relief that were typically available in equity." *Id.* at 256.

In 2002, this Court decided *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002). In *Knudson*, an ERISA fiduciary whose plan had paid the medical bills of an injured participant sought "reimbursement" from that participant after she reached a monetary settlement with the responsible tortfeasor. *Id.* at 207. The proceeds of the settlement had been deposited directly into a special needs trust, which was not made a party to the litigation. *Id.* at 208. For that reason, the *Knudson* Court held that the fiduciary had no recourse against the participant personally. *Id.* at 210.

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[2] The meaning of the phrase "appropriate equitable relief" is not only controversial, but also of unique importance. Section 502(a)(3) is the only provision in ERISA that permits a fiduciary to seek monetary relief from a participant or beneficiary who has violated the terms of her ERISA plan. And it is the only provision in ERISA that permits a participant or beneficiary to seek individualized monetary relief to remedy a statutory violation. *See generally* Victor O'Connell & Peter K. Stris, *ERISA & Equity*, 29 ABA J. LAB. & EMP. L. 125, 133–36 (2013).

In 2006, this Court decided *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006). *Sereboff* involved the same factual scenario as *Knudson* but with one critical difference: the funds sought by the fiduciary were paid to the named defendants and segregated by agreement of the parties pending the resolution of litigation. *Id.* at 360. The defendants argued that the "reimbursement" sought by the fiduciary was neither available as a restitutionary equitable lien (because the segregated settlement funds could not be traced back to the monies paid by the plan to cover the participant's medical bills), Brief of Petitioners at 17–23, Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356 (Jan. 19, 2006) (No. 05-260), nor as an equitable lien by agreement (because such a contractual remedy was not typically available in pre-merger courts of equity), *id.* at 24–27.

The *Sereboff* Court disagreed. It held that an equitable lien by agreement *was* typically available as a remedy in pre-merger courts of equity. *Sereboff*, 547 U.S. at 368. And, as such, there was no requirement that the fiduciary trace the settlement fund back to the monies paid by the plan to cover the participant's medical bills. *Id.* at 365.

The *Sereboff* Court did not, however, overrule the core teaching of *Knudson*. Indeed, because the settlement funds in *Sereboff* were being held in escrow pending resolution of the litigation, the Court expressly noted that the "impediment to characterizing the relief in [*Knudson*] as equitable [was] not present [because the plaintiff] sought its recovery through a constructive trust or equitable lien on a specifically identified fund, not from the [defendants'] assets generally, as would be the case with a contract action at law." *Id.* at 362–63.

In 2013, this Court decided *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013). In *McCutchen*, this Court—for a third time—evaluated the viability of a claim by an ERISA fiduciary whose plan had paid the medical bills of an injured participant that sought "reimbursement" from that participant after she reached a monetary settlement with a tortfeasor. *Id.* at 1543. As in *Sereboff* (and unlike in *Knudson*), the funds on which the fiduciary wished to place an equitable lien were indisputably in the possession of the defendants. *Id.*

In *McCutchen*, the defendants pressed an argument left open by the *Sereboff* Court—that the relief sought by the fiduciary was not "appropriate" because it contravened equitable common fund and make whole doctrines. *See* Brief for Respondents, US Airways, Inc. v. McCutchen, 133 S. Ct. 36 (Oct. 18, 2012) (No. 11-1285). The *McCutchen* Court rejected that argument. It held that the default equitable doctrines relied on by defendants will not apply under ERISA if they are disclaimed by the relevant plan documents. *McCutchen*, 133 S. Ct. at 1546.

Like the *Sereboff* Court, the *McCutchen* Court did not purport to overrule the core teaching of *Knudson*. To the contrary, it emphasized that the fiduciary in *McCutchen* (like the fiduciary in *Sereboff*) sought "equitable relief" because it claimed "'specifically identifiable funds' within the [defendants'] control. . . ." *Id.* at 1545 (emphasis added).

2. In the wake of *Mertens*, *Knudson*, *Sereboff*, and *McCutchen*, litigation by ERISA fiduciaries against plan participants often turns almost entirely on one critical question: may an ERISA fiduciary enforce an equitable lien against a defendant's general assets when specifically identified funds are no longer in his or her

possession? That question is exceptionally important and arises frequently in various types of ERISA cases. To appreciate the magnitude of the stakes involved, it is necessary to understand the three major settings in which the question presented is often, as in this case, outcome determinative: (1) healthcare cases, (2) disability cases, and (3) pension cases.

Healthcare cases. ERISA plans often pay the medical expenses of participants or beneficiaries who are injured in an accident. Most plans contain terms requiring those benefits to be repaid if the recipient later obtains a recovery from a responsible third party. Many plans expressly disclaim application of the common fund doctrine (*i.e.*, the plan will free-ride on the work of the participant's personal injury attorney) and authorize first-dollar recovery (*i.e.*, the plan will be reimbursed 100% even if the injured participant will receive nothing).[3] When there is a dispute over the existence or amount of the plan's lien, a fiduciary must act promptly to protect its interest. Otherwise, some or all of the disputed monies may be spent in good faith before resolution of the parties' dispute. In such cases, the question arises: can an "equitable lien" be enforced without showing that the funds on which the lien was placed remain in the defendant's possession?

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[3] Such provisions can be terribly unfair. *See, e.g.*, Vanessa Fuhrmans, *Accident Victims Face Grab for Legal Winnings*, WALL ST. J., (Nov. 7, 2007, 11:59 PM), http://www.wsj.com/news/articles/SB119551952474798582. As such, they are unenforceable under the law of most states. *See generally* Brendan S. Maher & Radha A. Pathak, *Understanding and Problematizing Contractual Tort Subrogation*, 40 LOY. U. CHI. L.J. 49 (2008).

Disability cases. ERISA plans often wish to require disability benefits to be repaid if a beneficiary receives Social Security Disability Income ("SSDI"). But section 407(a) of the Social Security Act shields SSDI benefits from attachment. *See* 42 U.S.C. § 407(a). To avoid running afoul of that prohibition, many ERISA plans are written to deem disability benefits as "overpayments" subject to recoupment if SSDI is received. Under these plans, when a plan participant becomes disabled, is paid benefits, and—months or years later—receives SSDI, the plan seeks recoupment for its "overpaid" benefits, which by that time have been spent on living expenses. Again, the question arises: can an "equitable lien" be enforced without showing that the funds on which the lien was placed remain in the defendant's possession?

Pension cases. A third common fact pattern arises in pension cases. Years after pension benefits are paid, a plan discovers that the benefit payments were too high as a result of a miscalculation by the plan. The plan's terms authorize recoupment. As one can imagine, the result of seeking such recoupment can be extremely harsh for individuals who have exhausted the funds that they honestly believed they were entitled to spend. Once again, the question presented is implicated.

3. Prior to this case, five circuits had held that an ERISA fiduciary may enforce an equitable lien against a defendant's general assets even if the fund has been dissipated, whereas two circuits had held that it may not. *Compare Cusson v. Liberty Life Assurance Co.*, 592 F.3d 215 (1st Cir. 2010) (plan may collect from defendant even though the fund was no longer in the defendant's possession or control), and *Thurber v. Aetna Life Ins. Co.*, 712 F.3d 654 (2d Cir. 2013) (same), and *Funk v. CIGNA Grp. Ins.*, 648 F.3d 182 (3d Cir. 2011) (same),

and *Longaberger Co. v. Kolt*, 586 F.3d 459 (6th Cir. 2009) (same), and *Gutta v. Standard Select Trust Ins. Plans*, 530 F.3d 614 (7th Cir. 2008) (same), *with Treasurer, Trustees of Drury Indus., Inc. Health Care Plan & Trust v. Goding*, 692 F.3d 888 (8th Cir. 2012) (when the defendant is no longer in possession of a fund, a Plan cannot enforce an equitable lien), and *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083 (9th Cir. 2012) (same).

Advocates on both sides have implored this Court to intervene and resolve the circuit split. *See, e.g.*, Petition for a Writ of Certiorari, First Unum Life Ins. Co. v. Bilyeu, 133 S.Ct. 1242 (October 26, 2012) (No. 12-526) (filed by plan fiduciary); Petition for a Writ of Certiorari, Thurber v. Aetna Life Ins. Co., 134 S.Ct. 2723 (July 26, 2013) (No. 13-130) (filed by plan participant).

Last year, this Court called for the views of the Solicitor General. *Thurber v. Aetna Life Ins. Co.*, 134 S. Ct. 381 (2013). In its invitation brief, the government acknowledged the existence of a (then) five-to-two circuit split. U.S. Br. at 6–9. It proceeded to explain in detail why the position of the majority is wrong because it directly contravenes *Knudson*, see U.S. Br. at 9–14, based on a fundamental misinterpretation of *Sereboff*, see U.S. Br. at 14–15.

The government recommended denial, however, on vehicle grounds. *See* U.S. Br. at 6–20 ("The first question presented implicates a conflict in the courts of appeals, but this petition is a poor vehicle for resolving it.") (initial capitalization removed); *id.* at 15–20 (explaining the specific vehicle problems present in *Thurber*). The *Thurber* petition was subsequently denied. *Thurber v. Aetna Life Ins. Co.*, 134 S. Ct. 2723 (2014).

B. Factual Background

On December 1, 2008, Petitioner Robert Montanile was seriously injured when a drunk driver ran a stop sign and struck his automobile. Pet. App. 6. Mr. Montanile underwent lumbar spinal fusion surgery and other treatment to alleviate his pain and loss of function. Pet. App. 6. He requires ongoing medical care and continues to suffer pain and physical limitations. Brief of Appellant at 5, Bd. of Trs. of the Nat'l Elevator Indus. Health Benefit Plan (May 27, 2014) (No. 14-11678) ("Montanile's C.A. Brief"). The National Elevator Industry Health Benefit Plan ("National Elevator Plan" or "Plan"), a billion-dollar multiemployer ERISA plan, paid Mr. Montanile's initial medical expenses in the amount of $121,044.02. Pet. App. 6; National Elevator Industry Health Benefit Plan: Form 5500 Annual Report at `48–50 (2009), *available at* https://efast.dol.gov/portal/app/disseminate?execution=e1s1 (to access the relevant document, use the Form 5500 Filing Search and search for Acknowledgement ID: 20101027094142P04000062234 3003) (listing approximately $1 billion in assets and over 500 participating employers).

Mr. Montanile retained counsel to sue the drunk driver and eventually settled his claims for a total of $500,000. Pet. App. 6. Out of that amount, Mr. Montanile paid his attorneys a $200,000 contingency fee and $63,788.48 in expenses. Pet. App. 6. Respondent Board of Trustees of the National Elevator Industry Health Benefit Plan ("Trustees"), which operates and administers the Plan, then asserted a right to be reimbursed the $121,044.02 the Plan had paid to Mr. Montanile's medical providers. Pet. App. 7. The Trustees sought reimbursement on a "first dollar" basis—*i.e.*, without any adjustment for Mr. Montanile's fees and

expenses or for the fact that he was not made whole. Pet. App. 7.

The Trustees relied on the following provision of the Plan's Summary Plan Description (the "Reimbursement Provision"):

> The Plan has a right to first reimbursement out of any recovery. Acceptance of benefits from the Plan for an injury or illness by a covered person, without any further action by the Plan and/or the covered person, constitutes an agreement that any amounts recovered from another party by award, judgment, settlement or otherwise, and regardless of how the proceeds are characterized, will promptly be applied first to reimburse the Plan in full for benefits advanced by the Plan due to the injury or illness and without reduction for attorneys' fees, costs, expenses or damages claimed by the covered person, and regardless of whether the covered person is made whole or recovers only a part of his/her damages.

Pet. App. 5–7.[4]

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[4] In the lower courts, Mr. Montanile argued that the Reimbursement Provision was not enforceable as a term of the National Elevator Plan because the Summary Plan Description did not qualify as the written instrument required by 29 U.S.C. § 1102. The Court of Appeals disagreed, holding that the terms of the Summary Plan Description "are enforceable, pursuant to § 1132(a)(3) because (1) no other document lays out the rights and obligations of plan participants and (2) the Trust Agreement contemplated the rights and obligations would be set forth in a separate document." Pet. App. 15. Mr. Montanile does not seek further review of the Court of Appeals' decision with respect to the enforceability of the Reimbursement Provision.

Mr. Montanile retained experienced ERISA attorney Brian S. King, who tried to negotiate a settlement with the Trustees for eight months. Montanile's C.A. Brief 6. When the parties reached an impasse, Mr. King requested that the Trustees either accept his final offer or file suit. Montanile's C.A. Brief 6. Mr. King told the Trustees that he would release the remaining settlement funds to Mr. Montanile if they failed to respond within 14 days. Montanile's C.A. Brief 6. After nearly a month passed with no response, Mr. Montanile asked his lawyer to distribute the rest of the funds to him, and Mr. King complied. Montanile's C.A. Brief 6–7.

Mr. Montanile then used the money to pay Mr. King's legal bills and to care for himself and his 12-year-old daughter. Montanile's C.A. Brief 7. Several months later, when significantly less than the $121,044.02 sought by the Trustees remained in Mr. Montanile's possession, the Trustees filed this lawsuit. Montanile's C.A. Brief 7.

C. Proceedings Below

The Trustees sued Mr. Montanile under 29 U.S.C. § 1132(a)(3) seeking reimbursement of benefits that the Plan paid to his medical providers. Pet. App. 7. Section 1132(a)(3) authorizes an ERISA fiduciary to seek "appropriate equitable relief" to "enforce the terms of the plan." 29 U.S.C. § 1132(a)(3). Relying on *Sereboff*, the Trustees sought reimbursement in the form of an equitable lien by agreement to "enforce the terms of the [National Elevator Plan]." Montanile's C.A. Brief 12.

After exchanging Rule 26(a) disclosures, the parties cross-moved for summary judgment. Montanile's C.A. Brief 12–13. Mr. Montanile opposed the Trustees' motion on the grounds that the reimbursement they sought did not constitute "appropriate equitable relief" because the

funds on which they wished to assert an equitable lien by agreement had been dissipated. Pet. App. 8. The district court acknowledged that "*Sereboff* did not address the issue of a beneficiary's dissipation of assets because the funds there were placed in a separate account through the duration of the case" and that "[t]he Eleventh Circuit has similarly not had occasion to address the issue of dissipation." Pet. App. 40. Nevertheless, believing that it was following "the overwhelming majority of circuit courts," the district court granted summary judgment to the Trustees. Pet. App. 40.

Mr. Montanile timely appealed. Pet. App. 9. He argued, in relevant part, that 29 U.S.C. § 1132(a)(3) authorizes equitable relief only to the extent available at common law. Montanile's C.A. Brief 15. And, at common law, an equitable lien by agreement could be enforced against specific property within the current possession and control of a debtor, but not against his general assets. Montanile's C.A. Brief 15. Because Mr. Montanile's settlement fund was dissipated in good faith prior to the initiation of this lawsuit, the magistrate judge erred in granting summary judgment to the Trustees and should have been reversed. Montanile's C.A. Brief 15.

After the parties had fully briefed Mr. Montanile's appeal, a divided three-judge panel of the Eleventh Circuit issued its decision in *AirTran Airways, Inc. v. Elem*. Pet. App. 46–76. In *AirTran*, the panel majority squarely decided the question presented, expressly adopting the position of the First, Second, Third, Sixth, and Seventh Circuits and rejecting the position of the Eighth Circuit, Ninth Circuit, and federal government. Pet. App. 53–54. Judge Martin dissented. *See* Pet. App. 65 (Martin, J., dissenting) ("Supreme Court precedent

makes clear that a plaintiff proceeding in equity to recover funds from a defendant must, at a minimum, show that those funds are presently in the defendant's possession.").

Shortly thereafter, the *AirTran* defendants retained undersigned counsel and timely petitioned for rehearing *en banc*. *See* Petition for Rehearing En Banc, AirTran Airways Inc. v. Elem., 767 F.3d 1192 (October 14, 2014) (No. 13-11738). In that petition, the *AirTran* defendants analyzed the existing circuit split and argued that the panel decision conflicted with both Supreme Court and Eleventh Circuit precedent.

While the *AirTran* petition for rehearing *en banc* was pending, another Eleventh Circuit panel heard oral argument on Mr. Montanile's appeal. Less than one week after hearing oral argument, that panel rejected Mr. Montanile's arguments and affirmed the decision below. Pet. App. 2.

The *Montanile* court noted that Mr. Montanile's primary argument "is now foreclosed by our recent holding in [*AirTran*]." Pet. App. 11. Indeed, after describing the *AirTran* holding, that funds are "specifically identifiable" and dissipation cannot "destroy the lien that attached" beforehand, the court concluded: "This holding binds our decision here. Accordingly, the Board can impose an equitable lien on Montanile's settlement, even if dissipated . . . ." Pet. App. 11.

On December 2, 2014, the petition for rehearing *en banc* in *AirTran* was denied. Pet. App. 77.

This petition followed.

REASONS FOR GRANTING THE PETITION

This petition presents a textbook case for further review. There is a widely-recognized and intractable circuit split involving eight of the thirteen circuits over the question presented. *See infra* 15–17. The decision below conflicts with relevant decisions of this Court. *See infra* 17–18. And, as leading advocates on both sides of this issue have made clear, immediate review is necessary because the question presented is exceptionally important and requires a uniform national answer. *See infra* 18–22.

I. As the United States Acknowledges, the Question Presented Has Divided the Circuits.

Prior to 2012, four circuits (the First, Third, Sixth, and Seventh) addressed the question presented: may an ERISA plan fiduciary enforce an equitable lien by agreement under 29 U.S.C. § 1132(a)(3) without first identifying a particular fund that is currently in the defendant's possession and control on which the lien may be enforced? Each of the initial four circuits to address the question agreed that its answer is yes. In chronological order, the four relevant decisions are: *Gutta v. Standard Select Trust Ins. Plans*, 530 F.3d 614 (7th Cir. 2008), *Longaberger Co. v. Kolt*, 586 F.3d 459 (6th Cir. 2009), *Cusson v. Liberty Life Assurance Co.*, 592 F.3d 215 (1st Cir. 2010), and *Funk v. CIGNA Grp. Ins.*, 648 F.3d 182 (3d Cir. 2011).

In 2012, two additional circuits (the Eighth and Ninth) addressed the question presented. These two circuits determined that the answer to the question presented is no. In chronological order, the two relevant decisions are: *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083 (9th Cir. 2012), *cert.*

denied, 133 S.Ct. 1242 (2013), and *Treasurer, Trustees of Drury Industries, Inc. Health Care Plan & Trust v. Goding*, 692 F.3d 888 (2012), *cert. denied*, 133 S. Ct. 1644 (2013).

In so holding, they created a square and openly acknowledged 4-2 circuit split. *See, e.g., Bilyeu*, 683 F.3d at 1094 ("We recognize that a number of circuits have [held] that a fiduciary can assert an equitable lien even if the beneficiary no longer possesses the specifically identified funds. We are unpersuaded by the view of those other circuits.").

In 2013, the Second Circuit became the seventh court of appeals to address the question presented. *See Thurber v. Aetna Life Ins. Co.*, 712 F.3d 654 (2d Cir. 2013), *cert. denied*, 134 S.Ct. 2723 (2014). The Second Circuit expressly "recognize[d] the existence of a Circuit split on the issue," *id.* at 663, and then proceeded to adopt the majority position, *id.* at 663–66, resulting in a 5-2 circuit split.

Upon Ms. Thurber's petition for a writ of certiorari, this Court invited the Solicitor General to file a brief expressing the views of the United States. *Thurber v. Aetna Life Ins. Co.*, 134 S. Ct. 381 (2013). The United States acknowledged that "the courts of appeals are divided on this question," U.S. Br. at 6, and proceeded to endorse the minority position, U.S. Br. at 9–15. Nevertheless, the government recommended against granting certiorari because a "predicate and case-specific question of plan interpretation could prevent the Court from reaching the first question presented." U.S. Br. at 15.

In the decision below and *AirTran*, the Eleventh Circuit joined the First, Second, Third, Sixth, and

Seventh Circuits in answering the question presented in the affirmative. The *AirTran* majority adopted the positions of "those circuit courts," Pet. App. 54, over a vigorous dissent in favor of the minority rule, Pet. App. 71 (Martin, J., dissenting) ("The majority relies on what I believe is a misapplication of *Sereboff*, accepted by some of our sister circuits, to characterize the recovery of assets no longer in the defendant's possession as equitable relief."). *AirTran* bound the panel in this case and, following denial of rehearing *en banc*, it is now the established law of the Eleventh Circuit.

II. The Decision Below Conflicts with this Court's Cases and Is Wrong on the Merits.

In the words of the dissenting judge in *AirTran*: "Supreme Court precedent makes clear that a plaintiff proceeding in equity to recover funds from a defendant must, at a minimum, show that those funds are presently in the defendant's possession." Pet. App. 65 (Martin, J., dissenting).

Specifically, the decision below—like each case in the circuit split majority—has taken a position that directly conflicts with the core teaching of *Knudson*: that "where 'the property [sought to be recovered] or its proceeds have been dissipated so that no product remains, [the plaintiff's] claim is only that of a general creditor,' and the plaintiff 'cannot enforce a constructive trust or an equitable lien upon other property of the [defendant].'" *Knudson*, 534 U.S. at 213–214 (quoting Restatement of Restitution and Unjust Enrichment § 215, cmt. a, at 867 (1936) (brackets in original) ("Restatement").

Moreover, as the United States has explained, the decision below cannot be reconciled with black-letter principles that this Court has held must undergird any

claim for equitable relief. *See, e.g.*, U.S. Br. at 12 (discussing, *inter alia*, Restatement § 161, cmt. e (an "equitable lien [could] be established and enforced only if there [was] some property which [was] subject to the lien" and where "the property subject to the equitable lien can no longer be traced, the equitable lien cannot be enforced.")).

To reiterate: in its *Thurber* invitation brief, the United States has explained in detail why the position of the First, Second, Third, Sixth, Seventh (and now Eleventh) Circuits is wrong and conflicts with this Court's ERISA section 502(a)(3) cases. *See* U.S. Br. at 9–14 (explaining why the panel majority's holding is wrong and conflicts with this Court's ERISA section 502(a)(3) cases); 14–15 (specifically explaining the misreading of *Sereboff*). This Court should grant the petition and expressly approve or reject the government's formal position. Absent such intervention, the lower courts will continue to be hopelessly divided on this important question of federal law.

III. Immediate Review Is Necessary Because the Question Presented is Exceptionally Important and Requires a Uniform National Answer.

As explained above, this Court has decided several cases about the meaning of "appropriate equitable relief" in section 502(a)(3) of ERISA. In the wake of those cases, litigation pursuant to that section has focused on the historical conditions that pre-merger equity courts would require for particular forms of relief. Thus, in the context of fiduciaries suing participants, litigation in a wide range of cases now turns almost entirely on the question presented.

The financial security of millions of Americans hangs on the answer. As of 2006, ERISA plans covered over 132 million people. *See* William Pierron & Paul Fronstin, *ERISA Pre-emption: Implications for Health Reform and Coverage*, EMP. BENEFIT RESEARCH INST., at 11 (Feb. 2008), *available at* http://www.ebri.org/pdf/briefs pdf/ebri_ib_02a-20082.pdf. And it is beyond dispute that billions of dollars are at stake in reimbursement and overpayment disputes. In the disability context alone, 653,000 beneficiaries received more than $9.8 billion in disability replacement income last year. *See* COUNCIL FOR DISABILITY AWARENESS, 2014 LONG TERM DISABILITY CLAIMS REVIEW (2014), *available at* http:// www.disabilitycanhappen.org/research/CDA_LTD_Clai ms_Survey_2014.pdf.

Not surprisingly given the stakes, eight of the thirteen circuits have squarely addressed the question presented, and advocates on both sides have urged this Court to intervene. On one hand, insurance industry trade groups have argued that the refusal to permit equitable liens threatens the continued viability of a functioning and affordable private-sector insurance market. *See, e.g.*, Brief for the American Council of Life Insurers, America's Health Insurance Plans, and the American Benefits Council as Amicus Curiae in Support of Petition for Writ of Certiorari, First Unum Life Ins. Co. v. Bilyeu, 133 S.Ct. 1242 (Nov. 28, 2012) (No. 12-526) (arguing that "the question presented is one of pressing nationwide importance" and that the position of the United States "threatens immediate, significant consequences for employee benefit plans nationwide, particularly those providing employees with disability income insurance.").

On the other hand, advocates for those covered by ERISA welfare plans have argued that the ability of plan fiduciaries to enforce an equitable lien on an individual's general assets is patently unfair and was never intended by Congress. *See, e.g.*, Petition for a Writ of Certiorari at 20, Thurber v. Aetna Life Ins. Co., 134 S.Ct. 2723 (July 26, 2013) (No. 13-130) (explaining that "disability benefits are 'designed, by definition, to replace [an employee's] wages during a period when [she is] unable to work'" and noting that "[t]hat fact creates 'an extremely strong presumption' that these benefits are immediately spent on life necessities—'groceries, rent and the electric bill.'") (quoting *D & H Therapy Assoc.'s, LLC v. Boston Mut. Life Ins. Co.*, 691 F. Supp. 2d 304 (D.R.I. 2010)). *See also* Roy F Harmon III, *The Conflict Between ERISA Overpayment Claims and Statutory Protection of SSDI Benefits*, HEALTH PLAN LAW (Dec. 22, 2008), http://www.healthplanlaw.com/?p=1017 (arguing that the imposition of an equitable lien when disability insurance payments have already been spent on ordinary living expenses is nothing more than an unlawful attempt to use ERISA as an end-run around section 407(a) of the Social Security Act, which shields SSDI benefits from attachment).

Regardless of one's position on the merits, it should be clear that the current circuit split is intolerable. In passing ERISA, Congress sought to implement a uniform legal regime with predictable entitlements and liabilities. *See Conkright v. Frommert*, 130 S. Ct. 1640, 1649 (2010); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002) (ERISA "induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred."). "[A] uniform

administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits," is desirable for both fiduciaries and beneficiaries because it reduces administrative costs and increases the certainty of benefits. *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)); *see generally* Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U. L. REV. 433 (2010).

Uniformity and predictability in the enforcement of reimbursement and overpayment provisions is now impossible. *Cf. Egelhoff*, 532 U.S. at 148 ("Uniformity is impossible if plans are subject to different legal obligations in different States.").

For the many regional and nationwide ERISA plans, the upshot is more expensive and less reliable plan administration. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). An administrator must familiarize herself with the jurisprudence and geographic reach of the various circuits whenever she wants to find out whether she has a valid lien. *See Egelhoff*, 532 U.S. at 148–49.

Meanwhile, ERISA participants and beneficiaries everywhere face heightened uncertainty about long-received benefits. *See, e.g.*, Petition for a Writ of Certiorari, Thurber v. Aetna Life Ins. Co. at 20, 134 S.Ct. 2723 (July 26, 2013) (No. 13-130) ("[W]ith no clear uniform rule governing the standards for equitable overpayment claims, employees who receive disability benefits will be uncertain of whether they may later be subject to reimbursement claims seeking money long since spent on daily life needs."). And such individuals within the Eighth and Ninth Circuits will inevitably face

unlawful collection efforts. *See* Maher & Stris, *supra*, at 440 ("carelessness by the promisor or its agents can result in a wrongful refusal to confer a benefit"); *id.* at 442 (complexity of promise increases uncertainty).

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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December 16, 2014

APPENDIX

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APPENDIX A

UNPUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 14-11678

BOARD OF TRUSTEES OF THE
NATIONAL ELEVATOR INDUSTRY
HEALTH BENEFIT PLAN,

Plaintiff-Appellee,

v.

ROBERT MONTANILE,

Defendant-Appellant.

On Appeal from the United States District Court
for the Southern District of Florida
D.C. Civil Action No. 12-80746-Civ-Brannon
(Honorable Steven M. Larimore)

Argued: November 21, 2014

Before: HULL, MARCUS, and DUBINA, *Circuit Judges*.

Filed: November 25, 2014

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OPINION OF THE COURT

HULL, *Circuit Judge*.

Defendant-appellant Robert Montanile appeals the district court's grant of summary judgment in the amount of $121,044.02 in favor of the plaintiff-appellee Board of Trustees of the National Elevator Industry Health Benefit Plan (the "Board") in its lawsuit against Montanile. After an automobile accident, Montanile received a settlement from a third-party tortfeasor for injuries he suffered in the accident. After that settlement, the plaintiff Board sued Montanile for reimbursement of the medical expenses already paid on defendant Montanile's behalf. After review, we affirm.

I. BACKGROUND

The facts of this case are largely undisputed. The Board is the named fiduciary and administrator of the National Elevator Industry Health Benefit Plan (the "Plan"). The Plan is an employee welfare benefit plan as defined by the Employee Retirement Income Security

Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq. At all relevant times, Robert Montanile was a covered employee under the Plan.

A. The Plan Documents

The parties filed three relevant documents relating to the Plan. The first document, the Restated Agreement and Declaration of Trust (the "Trust Agreement"), establishes the Plan for the benefit of members of the International Union of Elevator Constructors (the "Union").[1] The Trust Agreement also provides for the management of the Plan, governs Plan contributions, and creates general rules for claim management.

The Trust Agreement, however, does not provide the details regarding the health coverage and the benefits provided by the Plan and does not specify the procedures by which participants may seek benefits. Rather, the Trust Agreement gives the Board "full discretionary authority to adopt a Plan of Welfare Benefits, which sets forth eligibility requirements, type, amount, and duration of benefits that are to be provided to eligible employees . . " The Trust Agreement also provides that the "detailed basis on which payment of benefits is to be made pursuant to this Trust Agreement shall be set forth in the Plan of Welfare Benefits." "Such Plan of Welfare Benefits shall be subject to amendment by the Trustees from time to time as they may, in their discretion, determine " The Trust Agreement thus expressly

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[1] The record neither specifies Montanile's employer, nor expressly states that Montanile was a member of the Union. Nonetheless, the parties agree that Montanile was covered by the Plan at all relevant times.

contemplates that the participants' health coverage and benefits shall be set forth in a separate plan document from the Trust Agreement.

The second document, the National Elevator Bargaining Association Agreement with International Union of Elevator Constructors (the "Bargaining Agreement"), was effective from July 9, 2007, through July 8, 2012. The Bargaining Agreement specified that there would be a "Health Benefit Plan" and that any changes to the Plan would be part of the bargaining agreement, as follows:

> The Health Benefit Plan covering life insurance, sickness and accident benefits, and hospitalization insurance, or any changes thereto that are in accordance with the National Elevator Industry Health Benefit Plan and Declaration of Trust, shall be a part of this Agreement and adopted by all parties signatory thereto.

The Bargaining Agreement also provided that "the decision(s) to increase or decrease the benefits provided by the Health Benefit Plan are matters committed to the discretion of the Trustees ." The Bargaining Agreement did not specify any rights or obligations regarding the benefits that would be set forth in the Plan.

The third document, the 2005 version of the National Elevator Industry Health Benefit Plan Summary Plan Description (the "NEI Summary Plan Description"), was effective through, at least, May 2011. The 2005 version of the NEI Summary Plan Description was "written to reflect the changes in the Health Benefit Plan since the last version was printed." The document "provide[d] the required information about [Plan beneficiaries'] rights

and protection under the law in order to comply with the Employee Retirement Income Security Act of 1974."

The NEI Summary Plan Description was 87 pages long and contained, inter alia, detailed information regarding eligibility for health benefits, the extent of specific types of benefits, and claim-filing procedures. The NEI Summary Plan Description also included provisions regarding the benefits provided by the Plan when the losses were caused by a third party and the Plan's rights to recovery and reimbursement. The NEI Summary Plan Description set forth the Plan's rights to subrogation and first-recovery reimbursement out of any amounts recovered by the Plan participants from another party as follows:

> **The Plan's Right of Recovery**
>
> The Plan has the right to recover benefits advanced by the Plan to a covered person for expenses or losses caused by another party. . . .
>
> Amounts that have been recovered by a covered person from another party are assets of the Plan by virtue of the Plan's subrogation interest and are not distributable to any person or entity without the Plan's written release of its subrogation interest. . .
>
> The Plan's right of recovery also applies if benefits are advanced by the Plan to an individual on behalf of an injured covered person or to the covered person's assignee.
>
> **The Plan's Right of Reimbursement**
>
> The Plan has a right to first reimbursement out of any recovery. Acceptance of benefits from the

> Plan for an injury or illness by a covered person, without any further action by the Plan and/or the covered person, constitutes an agreement that any amounts recovered from another party by award, judgment, settlement or otherwise, and regardless of how the proceeds are characterized, will promptly be applied first to reimburse the Plan in full for benefits advanced by the Plan due to the injury or illness and without reduction for attorneys' fees, costs, expenses or damages claimed by the covered person, and regardless of whether the covered person is made whole or recovers only part of his/her damages.

(Emphasis added). While the NEI Summary Plan Description had this reimbursement provision, the Trust Agreement and the Bargaining Agreement did not have a similar provision.

B. Montanile's Injury and the Reimbursement Dispute

On December 1, 2008, Montanile was injured in a car accident involving a drunk driver. Montanile suffered injuries to his neck and lower back, requiring lumbar spinal fusion surgery and other medical treatment to reduce his pain and loss of function. The Plan paid Montanile's initial medical expenses of $121,044.02.

Montanile retained counsel and initiated a civil lawsuit against the driver of the other car for negligence. Montanile eventually obtained a $500,000 settlement from the other driver. Out of the settlement funds, Montanile paid his attorneys a $200,000 contingency fee and $63,788.48 to reimburse out-of-pocket expenses.

After defendant Montanile accepted the settlement, the plaintiff Board, as fiduciary for the Plan, asserted that the Plan had the right to be reimbursed out of the settlement proceeds for the medical expenses paid on Montanile's behalf. The Board and Montanile, through counsel, attempted to negotiate a resolution from June 2011 through January 2012. After settlement discussions reached an impasse, the Board filed a single-count ERISA lawsuit to enforce the Plan's reimbursement provision.

C. District Court Proceedings

In its complaint, the plaintiff Board alleged that "the National Elevator Industry Health Benefit Plan Summary Plan Description" met ERISA's requirement of a written plan and summary plan description. The Board claimed that, pursuant to the NEI Summary Plan Description, Montanile was required to fully reimburse the Plan from the settlement payment he received.

The plaintiff Board further alleged that "all or part of the settlement proceeds are within the actual or constructive possession of" Montanile and claimed that the Plan was "entitled to equitable restitution in the form of a constructive trust or equitable lien with respect to the disputed funds held in Defendant [Montanile's] actual or constructive possession." The Board therefore requested that defendant Montanile "be ordered to turn over to the Plan any settlement funds in his actual or constructive possession (up to the amount of the benefits advanced by the Plan on his behalf) in order to enforce the written terms of the Plan of Welfare Benefits and ERISA."

In his answer, defendant Montanile admitted that the Plan "described in paragraph 11 of the Complaint" is one

of the governing documents for the ERISA group health benefits Plan at issue in this case." However, Montanile later reversed course and moved for summary judgment, arguing, inter alia, that the Bargaining Agreement and the Trust Agreement were the only "governing plan documents." Montanile contended that any subrogation or reimbursement rights the Plan asserted must accordingly be found in one of those two documents.

The Board opposed Montanile's summary-judgment motion. The Board contended that the NEI Summary Plan Description was a governing Plan document that could establish subrogation and reimbursement rights because the Bargaining Agreement and the Trust Agreement "reference a separate plan document that sets forth eligibility requirements, type, amount, and duration of benefits that are to be provided to covered persons." According to the Board, the NEI Summary Plan Description was that document; no other document met the qualifications of a written plan of welfare benefits, and no other document defined a covered person's right to benefits under the Plan. The Board also filed its own cross-motion for summary judgment.

Montanile opposed the Board's cross-motion for summary judgment, arguing that the reimbursement sought by the Board was not "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3)(B) because the funds on which the Board wished to assert an equitable lien had been dissipated through payments Montanile had made since receiving the settlement.

The district court found that the NEI Summary Plan Description was an enforceable, governing plan document required by ERISA. Specifically, the district court stated that "[t]here can be no doubt that the NEI

Summary Plan Description functioned as both the governing Plan document and the summary plan description mandated by ERISA." The district court also then found that reimbursement was appropriate equitable relief under § 1132(a)(3)(B) because "[t]he settlement proceeds represent an identifiable fund to which the Plan's lien attached and such proceeds belong 'in good conscience' to the Plan to the extent of the medical expenses it paid on Defendant's behalf." Accordingly, the district court denied Montanile's motion for summary judgment and granted summary judgment in favor of the Board in the amount of $121,044.02, which was what the Board had paid as Montanile's medical expenses.

Montanile timely appealed.

II. RELEVANT ERISA PROVISIONS

ERISA authorizes plan participants and beneficiaries to bring civil actions "to recover benefits due" and "to enforce . rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). The statute also authorizes participants, beneficiaries, and fiduciaries of a plan to seek "appropriate equitable relief to enforce the terms of the plan." Id. § 1132(a)(3)(B).

The statute does not specify where the "terms of the plan" must be found, but it does require every "employee benefit plan" to be "established and maintained pursuant to a written instrument." Id. § 1102(a)(1). The written instrument "shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan." Id.

In the same section as the "written instrument" provision, ERISA requires that each plan must

> (1) provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan . . . ,
>
> (2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan . . ,
>
> (3) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan, and
>
> (4) specify the basis on which payments are made to and from the plan.

Id. § 1102(b). The text of the statute, however, does not state that the four requirements of each plan must be in the same "written instrument" that establishes and maintains the Plan.

Nonetheless, ERISA mandates that a "summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries" of the plan. Id. § 1022(a). "The summary plan description . . shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." Id.

III. DISCUSSION

On appeal, Montanile argues that the district court erred in finding that the Board could impose an equitable lien on the settlement funds because the funds had been spent or dissipated. As both parties recognize in their

supplemental briefs, Montanile's argument is now foreclosed by our recent holding in AirTran Airways, Inc. v. Elem, 767 F.3d 1192 (11th Cir. 2014). This Court held in AirTran that, pursuant to § 1132(a)(3)(B), an equitable lien immediately attached to settlement funds where a plan provision's unambiguous terms gave the plan a first-priority claim to all payments made by a third party. Id. at 1198. The AirTran court held that the settlement funds were "specifically identifiable," and a plan participant's dissipation of the funds thus "could not destroy the lien that attached before" the dissipation. Id. (emphasis in original). This holding binds our decision here. Accordingly, the Board can impose an equitable lien on Montanile's settlement, even if dissipated, if his health benefit Plan gave the Plan a first-priority claim to the settlement payments Montanile received.

Here, the NEI Summary Plan Description gave the Plan a first-priority claim to settlement proceeds Montanile received from a third party. Therefore, as an alternative argument, Montanile contends that the NEI Summary Plan Description is not a governing Plan document and thus its terms are not enforceable as part of the Plan. Because the district court concluded that the NEI Summary Plan Description was an enforceable, governing Plan document at the summary- judgment stage, we must review de novo, rather than for clear error. See Wooden v. Bd. of Regents of Univ. Sys. of Georgia, 247 F.3d 1262, 1271 n.9 (11th Cir. 2001) ("[A] district court does not make factual findings in deciding a summary judgment motion, so no question of clear error review . . . arises here.").

A. Dual Function of a Summary Plan Description

First, Montanile argues that a single document, such as the NEI Summary Plan Description, cannot be both (1) a written instrument that sets forth the Plan's terms, as required by § 1102(a)(1), and (2) a summary plan description, as required by § 1022.[2]

We have previously indicated that a single document can serve both functions. See Alday v. Container Corp. of Am., 906 F.2d 660, 666 (11th Cir. 1990) (stating that a summary plan description "clearly functioned as the plan document required by ERISA" and "unambiguously set out the rights of the parties"). Indeed, in his response to the Board's cross-motion for summary judgment in the district court, "Montanile acknowledge[d] that ERISA plan fiduciaries may draft a document that operates both as the governing plan document and the SPD mandated by ERISA "[3] However, Montanile on appeal now contends that the Supreme Court's decision in CIGNA Corp. v. Amara, 563 U.S. ___, 131 S. Ct. 1866, 1870 (2011), requires us to hold otherwise.

In Amara, the original provisions contained in CIGNA's governing pension plan document provided that employees would receive a pension plan in the form of a defined-benefit annuity. Id. at ___, 131 S. Ct. at 1871. In

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[2] Although the plaintiff Board claims that defendant Montanile waived this argument, we need not resolve that issue as it lacks merit in any event.

[3] In the district court, Montanile conceded that a summary plan description could serve as a governing document, but contended that the NEI Summary Plan Description did not so serve. We address this argument infra, Part III.B.

November 1997, CIGNA announced in a newsletter that it was converting the pension plan into a plan with "cash balance" individual retirement accounts. Id. at ___, 131 S. Ct. at 1871-72. In 1998, CIGNA effected the change to cash-balance accounts in new governing plan documents. Id. However, the district court found that CIGNA intentionally misled its employees in the November 1997 written communication regarding the changes. Id. at ___, 131 S. Ct. at 1872. The district court then reformed the plan's provisions to be consistent with the November 1997 written communication regarding the change. Id. at ___, 131 S. Ct. at 1875-76. Importantly, the district court's reformation did not merely reinstate the defined-benefit plan. Instead, the district court created a plan that included terms that were not found in either the original plan or the new plan. See id. at ___, 131 S. Ct. at 1876-77.

After granting certiorari, the Supreme Court held that the district court lacked the power, pursuant to § 1132(a)(1), to change the terms of the plan where the change imposed by the court "seems less like the simple enforcement of a contract as written and more like an equitable remedy." Id. at ___, 131 S. Ct. at 1876-77. The Supreme Court rejected the proposition that the 1997 written communication, even if construed as a statutorily-required plan summary, "necessarily may be enforced as the terms of the plan itself."[4] Id. at ___, 131 S. Ct. at

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[4] Although the misleading communication at issue in Amara was a summary of a material plan change, both summaries of material changes made to ERISA plans and the standard summary plan descriptions are governed by 29 U.S.C. § 1022(a). Accordingly, the Supreme Court indicated that its analysis applied with equal force to summary plan descriptions. See Amara, 563 U.S. at ___, 131 S. Ct. at 1877 ("[W]e cannot agree that the terms of statutorily required plan

(continued ...)

1877 (emphasis added). The Supreme Court stated that the syntax of § 1022(a), "requiring that participants and beneficiaries be advised of their rights and obligations 'under the plan,' suggests that the information about the plan provided [in a summary plan description] is not itself part of the plan." Id. (emphasis in original).

Additionally, the Supreme Court stated that it had "no reason to believe that the statute intends to mix the responsibilities [of plan sponsor and plan administrator] by giving the administrator the power to set plan terms indirectly by including them in the summary plan descriptions." Id. Finally, the Supreme Court noted that "[t]o make the language of a plan summary legally binding could well lead plan administrators to sacrifice simplicity and comprehensibility in order to describe plan terms in the language of lawyers." Id. at ___, 131 S. Ct. at 1877-78.

Although "dicta from the Supreme Court is not something to be lightly cast aside," Peterson v. BMI Refractories, 124 F.3d 1386, 1392 n.4 (11th Cir. 1997), the facts of this case are materially distinguishable from the facts of Amara. To begin with, the Supreme Court's holding in Amara—that the district court lacked the power under § 1132(a)(1) to enforce an equitable remedy—does not impact our analysis. The provision under which the Board seeks relief here, § 1132(a)(3), specifically grants the Board the right to seek equitable relief. 29 U.S.C. § 1132(a)(3)(B).

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summaries (or summaries of plan modifications) necessarily may be enforced (under § 502(a)(1)(B)) as the terms of the plan itself.").

Furthermore, Amara only precludes courts from enforcing summary plan descriptions, pursuant to § 1132(a)(1), where the terms of that summary conflict with the terms specified in other, governing plan documents. However, the Amara Court had no occasion to consider whether the terms of a summary plan description are enforceable where it is the only document that "specif[ies] the basis on which payments are made to and from the plan," as required by § 1102(b). Cf. Eugene S. v. Horizon Blue Cross Blue Shield of New Jersey, 663 F.3d 1124, 1131 (10th Cir. 2011) (holding that Amara did not prevent a court from giving deferential review to a Plan's decision regarding a term found only in a summary plan description because "the SPD does not conflict with the Plan or present terms unsupported by the Plan; rather, it is the Plan" (emphasis in original)). Indeed, the Amara Court's rejection of the proposition that summary plan descriptions "necessarily may be enforced as the terms of the plan itself" leaves open the possibility that terms in those summaries may, at times, be enforced, even though they are not always enforceable. See Amara, 563 U.S. at ___, 131 S. Ct. at 1877 (emphasis added).

Here, the NEI Summary Plan Document does not conflict with any pre-existing plan documents that set out the rights of the parties—because no other written instrument specifies the benefits and obligations of Plan participants. The terms specified in that summary plan description are enforceable, pursuant to § 1132(a)(3) because (1) no other document lays out the rights and obligations of plan participants and (2) the Trust Agreement contemplated the rights and obligations would be set forth in a separate document.

B. The Governing Documents

In the alternative, Montanile argues that, even if a summary plan description theoretically could serve both roles, the district court erred by finding that terms found only in the NEI Summary Plan Description were enforceable because the Trust Agreement constituted the sole governing Plan document.[5]

Enforceable plan terms may be found in more than one document. See Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 83, 115 S. Ct. 1223, 1230 (1995) ("In the words of the key congressional report, '[a] written plan is to be required in order that every employee may, on examining the plan documents, determine exactly what his rights and obligations are under the plan.'" (quoting H.R. Conf. Rep. No. 93-1280, at 297, as reprinted in 1974 U.S.C.C.A.N. 5038, 5077-78) (emphasis added)). Montanile does not dispute this point.

Here, the terms of the Trust Agreement demonstrate that the enforceable terms of the Plan are to be found in more than just that one document. In particular, the Trust Agreement does not "specify the basis on which payments are made to and from the plan," as required by § 1102(b). Rather, it states that the Trustees will establish the "detailed basis on which payment of benefits is to be made" in "the Plan of Welfare Benefits." Although the NEI Summary Plan Description does not carry the title contemplated by the Trust Agreement, it serves the precise function as that proposed for the "Plan of Welfare Benefits." Indeed, Montanile initially

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[5] Montanile no longer contends that the Bargaining Agreement is a governing Plan document.

admitted that the NEI Summary Plan Description was "one of the governing documents for the ERISA group health benefits Plan at issue in this case" before reversing course in his motion for summary judgment.

Furthermore, if the enforceable terms of the Plan were limited to those found in the Trust Agreement, there would be no governing document that specifies Plan participants' rights or obligations regarding benefits. Plan participants would thus be barred from enforcing their rights under the straight-forward provisions of § 1132(a)(1). And, if we held that the Board could not use the equitable provision of § 1132(a)(3) to enforce the Plan's right to reimbursement, it would not be clear that Plan participants could enforce in equity any participant rights found solely in the NEI Summary Plan Description. We refuse to embrace such an outcome. See Admin. Comm. of Wal-Mart Stores, Inc. Associates' Health & Welfare Plan v. Gamboa, 479 F.3d 538, 544 (8th Cir. 2007) ("ERISA requires a written arrangement, and no other document exists by which group health benefits are provided... It would be nonsensical to conclude that the plain language of the Plan requires an interpretation that renders no plan at all under the terms of ERISA.").

We hold that the NEI Summary Plan Description constitutes a written instrument that sets out enforceable "terms of the plan." See Alday, 906 F.2d at 666. Accordingly, pursuant to § 1132(a)(3), the Board could enforce the term found in the NEI Summary Plan Description that gave it a subrogation interest in sums recovered from third parties.

IV. CONCLUSION

For all of the foregoing reasons, we affirm the district court's grant of summary judgment in favor of the Board and denial of Montanile's summary-judgment motion.

AFFIRMED.

APPENDIX B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 12-80746-Civ-Brannon

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Plaintiff,

v.

ROBERT MONTANILE,

Defendant.

ORDER ON CROSS-MOTIONS FOR SUMMARY JUDGMENT

Larimore, J. **March 17, 2014**

THIS CAUSE is before the Court on Plaintiff s suit for the reimbursement of funds it expended to cover Defendant's accident-related medical expenses from the proceeds of Defendant's later settlement with a third-party tortfeasor. The parties agree that this case is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, et seq., and the parties have cross-moved for summary judgment (DE 35 & DE 36). Both motions are fully briefed and ripe for review. For the following reasons, the Court finds that

Plaintiff is entitled to summary judgment and Defendant is not.

I. STANDARD OF REVIEW

A court "shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); see also Celotex Corp. v. Catrett, 477 U.S. 317, 323 (1986); Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48 (1986). "An issue of fact is 'material ' if it is a legal element of the claim under the applicable substantive law which might affect the outcome of the case." Allen v. Tyson Foods, Inc., 121 F.3d 642, 646 (11th Cir. 1997). In making this determination, a court must review all evidence and draw all reasonable inferences in favor of the non-moving party. Chapman v. Al Trans., 229 F.3d 1012, 1023 (11th Cir. 2000). The court will not weigh the evidence or find facts; rather, it determines only if there is sufficient evidence upon which a reasonable juror could find for the non-moving party. Morrison v. Amway Corp., 323 F.3d 920, 924 (11th Cir. 2003).

Cross-motions for summary judgment do not change the standard and a court must consider each such motion separately. American Bankers Ins. Group v. U.S., 408 F.3d 1328, 1331 (11th Cir. 2005); Ernie Haire Ford, Inc. v. Universal Underwriters Ins. Co., 541 F. Supp. 2d 1295, 1297-98 (M.D. Fla. 2008). Each moving party carries the initial burden of proof and meets this burden by identifying portions of the record that demonstrate the absence of any genuine issue of material fact. Celotex, 477 U.S. at 322-24. Once the initial burden is satisfied, the burden shifts to the opposing party to demonstrate through the production of probative evidence that there remains a genuine issue of fact to be tried. Id.

II. STATEMENT OF FACTS

The facts of this case are largely undisputed. Plaintiff Board of Trustees is the named fiduciary and administrator of the National Elevator Industry Health Benefit Plan ("Plan") (DE 36 at 1). The Plan is an "employee welfare benefit plan" as that term is defined in ERISA (Id.). At all relevant times, Defendant was a covered employee under the Plan (Id. at 2).

The parties have filed three documents relating to the Plan. The first document—a "Restated Agreement and Declaration of Trust" dated May 20, 1976 ("Declaration of Trust")—contains a section titled "Plan of Welfare Benefits" stating:

> Benefits. The Trustees shall have full discretionary authority to adopt a Plan of Welfare Benefits, which sets forth eligibility requirements, type, amount, and duration of benefits that are to be provided to eligible employees, based on what is actuarially determined to be within the financial limitations of the National Elevator Industry Welfare Plan, provided, however that no benefits, other than welfare benefits, may be provided for or paid under this Agreement and Declaration of Trust
>
> . . .
>
> Written Plan of Benefits. The detailed basis on which payment of benefits is to be made shall be set forth in the Plan of Welfare Benefits. Such Plan of Welfare Benefits shall be subject to amendment by the Trustees from time to time as they may, in their discretion, determine. .

(DE 36-2 at 33-34). The second document—the "National Elevator Industry Health Benefit Plan Summary Plan

Description" with an introductory letter dated January 2005 ("SPD")—contains a section titled "Other Party Liability Claims" stating:

> **The Plan's Right of Recovery**
>
> The Plan has the right to recover benefits advanced by the Plan to a covered person for expenses or losses caused by another party. If a covered person is injured or becomes ill under circumstances where another party is directly or indirectly liable for the illness or injury, the Plan is only obligated to provide covered benefits resulting from that illness or injury that exceed any amounts recovered from another party (whether or not the amount is recovered is designated to cover medical expenses).
>
> Amounts that have been recovered by a covered person from another party are assets of the Plan by virtue of the Plan's subrogation interest and are not distributable to any person or entity without the Plan's written release of its subrogation interest. However, amounts recovered by such covered person from another party in excess of benefits paid by the Plan are the separate property of such covered person. Unless otherwise noted in this SPD, amounts received from an individual health insurance policy for which the injured covered person or other family member has paid premiums are also the separate property of the covered person.

The Plan's Right of Reimbursement

The Plan has a right to first reimbursement out of any recovery. Acceptance of benefits from the Plan for an injury or illness by a covered person, without any further action by the Plan and/or the covered person, constitutes an agreement that any amounts recovered from another party by award, judgment, settlement or otherwise, and regardless of how the proceeds are characterized, will promptly be applied first to reimburse the Plan in full for benefits advanced by the Plan due to the injury or illness and without reduction for attorneys' fees, costs, expenses or damages claimed by the covered person , and regardless of whether the covered person is made whole or recovers only part of his/her damages.

Acceptance of benefits from the Plan for an illness or injury by a covered person constitutes the covered person's agreement to file a claim for benefits against any party who is liable for the injury or illness to the covered person and to file claims under any and all applicable policies of insurance or self-insurance, including but not limited to homeowners insurance, auto insurance, or any liability policy held for a public or commercial entity. The covered person must promptly file a claim for damages against any party liable and any such applicable policy and notify the Plan of his/her claim against such parties or policies or other recovery efforts. The covered person agrees that neither he/she nor anyone acting on his/her behalf will settle any claim relating to the injury or illness without the written consent of the Plan. The Plan reserves the

> right to make all decisions with respect to its rights of subrogation and recovery.

(DE 36-4 at 26). The third document—the "National Elevator Bargaining Association Agreement with International Union of Elevator Constructors July 9, 2007 to July 8, 2012" ("Bargaining Association Agreement")—contains a section titled "Health Benefit Plan" stating:

> The Health Benefit Plan covering life insurance, sickness and accident benefits, and hospitalization insurance, or any changes thereto that are in accordance with the National Elevator Industry Health Benefit Plan and Declaration of Trust, shall be a part of this Agreement and adopted by all parties signatory thereto.

(DE 35-3 at 42).

On December 1, 2008, Defendant was injured in a car accident involving a drunk driver, and the Plan paid $121,044.02 to cover the cost of his medical expenses (DE 1 at 2; DE 36 at 2-3; DE 39-3, Montanile Aff. ¶ 2). Defendant later retained counsel to pursue compensation for his accident-related injuries in the form of a civil negligence suit against the other car's driver and ultimately obtained a $500,000 settlement (DE 35 at 2; DE 39 at 3; DE 39-3, Montanile Aff. ¶ 5). In accordance with its fiduciary duty to enforce Plan terms, Plaintiff asserted a right to be reimbursed for the medical expenses paid on Defendant's behalf out of the settlement proceeds and the parties attempted, through counsel, to negotiate a resolution from June 2011 through January 2012 (DE 39-3, Montanile Aff. ¶ 8; DE 35-2, King Aff. ¶¶ 3-5). After a resolution could not be reached, on July 11, 2012, Plaintiff filed the instant

single-count ERISA suit to enforce the reimbursement provision in its Plan (DE 1).

III. ANALYSIS

ERISA authorizes a plan fiduciary to bring a civil action "to obtain appropriate equitable relief" to enforce the terms of a plan. 29 U.S.C. § 1 132(a)(3)(B). In a recent case, the Supreme Court reaffirmed its prior holding that a health plan fiduciary like Plaintiff may bring suit under § 1132(a)(3)(B) to enforce a provision for reimbursement. US Airways, Inc. v. McCutchen, 133 S. Ct. 1537, 1545 (2013). Such a claim, the Supreme Court explained , is the modem-day equivalent of an action in equity to enforce a contract-based lien–called an "equitable lien 'by agreement.'" Id. (quoting Sereboff v . Mid Atlantic Medical Servs., Inc., 547 U.S. 356, 364-65 (2006)).

Two disputed legal issues emerge from the parties' summary judgment briefing: (1) whether the Summary Plan Description's "Other Party Liability Claims" provision ("OPL") creates an enforceable right to reimbursement from Defendant's post-accident settlement proceeds, and (2) if so, whether such reimbursement is "appropriate equitable relief" under ERISA.

1. *Plaintiff's Right to Reimbursement*

Plaintiff satisfies the basic requirements for seeking relief under 29 U.S.C. § 1 132(a)(3)(B). Plaintiff is an ERISA "fiduciary" seeking—as in McCutchen and Sereboff—relief that is "equitable" in nature. In its fiduciary capacity, Plaintiff relies upon the OPL in the Summary Plan Description as creating a valid and enforceable right to reimbursement. Defendant contends that the Summary Plan Description is not a governing plan document, and thus its OPL provision cannot be

relied upon to establish a right not otherwise included in what Defendant views as the only two governing plan documents—namely, the Declaration of Trust and the Bargaining Association Agreement.

The Court readily finds for Plaintiff on this first issue. ERISA defines summary plan descriptions as one of many plan documents that plan administrators must provide to plan participants. 29 U.S.C. § 1024; Alday v. Container Corp. of Am., 906 F.2d 660, 665 (11th Cir. 1990). ERISA mandates that summary plan descriptions "shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C.A. § 1022(a); see also McKnight v. Southern Life & Health Ins. Co., 758 F.2d 1566, 1570 (11th Cir. 1985)("ERISA provides that the summary shall be an accurate and comprehensive document that reasonably apprises the employees of their rights under the plan."). The Eleventh Circuit has held that the terms of a summary plan description that "clearly functioned as the plan document required by ERISA" and unambiguously conferred on the employer the right to modify a medical insurance plan were controlling to the exclusion of other plan-related communications. Alday, 906 F.2d at 666.

Defendant's argument that the Summary Plan Description is not an enforceable plan document is unavailing. Importantly, the Summary Plan Description supplements and is not in conflict with the other two Plan documents of record. Both the Declaration of Trust and the Bargaining Association Agreement expressly refer to a separate document that contains more detailed information about the nature and scope of benefits available to Plan participants. See DE 36-2 at 33 ("The

Trustees shall have full discretionary authority to adopt a Plan of Welfare Benefits, which sets forth eligibility requirements, type, amount, and duration of benefits . . ."); DE 35-3 at 42 ("The Health Benefit Plan covering life insurance, sickness and accident benefits, and hospitalization insurance, or any changes thereto that are in accordance with the National Elevator Industry Health Benefit Plan and Declaration of Trust, shall be a part of this Agreement and adopted by all parties signatory thereto."). Despite the references to different document titles—*i.e.*, "Plan of Welfare Benefits" and "Health Benefit Plan"—the Summary Plan Description is the only document out of the trio of documents that fits the bill of the separate benefit Plan document contemplated by the other two. The Summary Plan Description is also the only document that clearly sets out the parties' rights and responsibilities concerning health benefit eligibility and coverage, including but not limited to Defendant's right to receive medical benefits in the first place.

Undisputed affidavit testimony supports the conclusion that the Summary Plan Description is a governing plan document. Plaintiff submits two affidavits by its Director of Health Claims Administration, John McGowan, averring that the Plan was created by the Declaration of Trust and that, pursuant to the terms in the Declaration of Trust, Plaintiff approved the Summary Plan Description for administration as the only formal Plan document setting forth the rights and benefits of Plan participants. (DE 36-1, McGowan Aff. ¶¶ 4, 6-9; DE 41-1, McGowan Supp. Aff. ¶ 4). Defendant offers no factual evidence to dispute or otherwise challenge these averments.

Viewing the undisputed evidence as a whole, including the documents and Mr. McGowan's

unchallenged affidavit statements, the Summary Plan Description is clearly contemplated by the other two documents and is the only document containing the requisite information about eligibility requirements, type, amount, and duration of benefits for Plan participants. There can be no doubt that the Summary Plan Description functioned as both the governing Plan document and the summary plan description mandated by ERISA. In plain language, the Summary Plan Description's OPL clearly notifies Defendant and other Plan participants of Plaintiff s right to be reimbursed from any settlement proceeds recovered from a liable third party. Neither the Declaration of Trust nor the Bargaining Association Agreement contain any language to contradict this express right to reimbursement and a reasonable person in Defendant's position would have expected to reimburse Plaintiff. As the saying goes, what is good for the goose is good for the gander. Just as Defendant and other Plan participants were entitled to justifiably rely on the Summary Plan Description's provisions for medical benefit coverage, Plaintiff is entitled to rely on the Summary Plan Description's provision for reimbursement as a condition tied to such coverage.

Defendant cites Cigna Corp. v. Amara, 131 S.Ct. 1866 (2011) for the proposition that a summary plan description can never serve as an ERISA plan document. Cigna does not sweep so broadly. There, several Cigna employees on behalf of 25,000 beneficiaries challenged Cigna's adoption of a new contribution plan on grounds that the summary plan description and prior Cigna announcements describing the plan were inaccurate and misleading. Id. at 1870-71. After finding that Cigna's inaccurate disclosures violated ERISA, a federal district

court reformed the plan's terms and ordered benefit payments under the judicially reformed plan. Id.

The Supreme Court reversed, finding that reformation was not an available remedy under ERISA's recovery-of-benefits-due provision, 29 U.S.C. § 1132(a)(1)(B), which authorizes a plan beneficiary to bring a civil action to recover benefits due under plan terms. Id. In so ruling, the Supreme Court rejected an argument that the terms of summary plan descriptions "may be enforced as the terms of the plan itself[,]" holding instead that "summary documents, important as they are, provide communication with beneficiaries about the plan, but that their statements do not themselves constitute the terms of the plan for purposes of § [1132](a)(1)(B)." Id. at 1877-78 (emphasis in original). At the core of this holding is the requirement that there be a conflict between the language of a summary plan description and a controlling plan document before the summary plan's terms can be ignored or overridden. Here, no such conflict exists. Unlike the summary communications at issue in Cigna, the SPD in this case did not inaccurately describe plan information or add new inconsistent terms. The Declaration of Trust authorized Plaintiff to establish a health benefit plan, which Plaintiff did when it approved the Summary Plan Description. Since the Summary Plan Description and other Plan documents are not in conflict, the important policy of protecting Plan members from inaccurate information—a policy concern of great import in Cigna—is not implicated here. As the only Plan document that describes in detail the nature and extent of health benefits coverage, the Summary Plan Description is a governing ERISA plan document and the unambiguous OPL, in effect at the time of Defendant's accident, provides Plaintiff with the right to seek reimbursement from Defendant's post-accident settlement proceeds. To

conclude otherwise would be contrary to the purpose and spirit of ERISA.

Defendant makes two additional arguments, both of which merit only brief discussion. First, Defendant contends the OPL is unenforceable because the Declaration of Trust requires that any plan amendments, such as the Summary Plan Description provision for reimbursement, be actuarially based. A plain reading of the Declaration of Trust reveals, however, that consultation with an actuary to determine if a proposed amendment is "actuarially within the financial limitations" of the Plan is required only in the case of an "amendment that increases the amount of the benefits or adds additional benefits." (DE 36-2 at 34). No party asserts that the OPL increased or added benefits; indeed, the OPL did just the opposite by requiring that the Plan be reimbursed out of any third-party recovery. Thus, this argument fails.

Second, Defendant contends that the OPL is unenforceable based on Plaintiff's failure to ensure compliance with ERISA 's anti-inurement provisions or otherwise provide Defendant with information about how Plaintiff will distribute any funds recovered from Defendant. Defendant's argument in this regard is misplaced. The Court is unaware of any authority, and Defendant has cited none, that conditions Plaintiff's ERISA claim for reimbursement on Plaintiff's demonstrated compliance with ERISA's anti-inurement provisions. Thus, the Court rejects this argument.

2. *Whether Reimbursement is "Appropriate" under ERISA*

Having concluded that Plaintiff is entitled to seek reimbursement, the Court turns next to Defendant's argument that reimbursement is not "appropriate

equitable relief" under ERISA because: (1) Defendant's recovery did not make him whole and Plaintiff has expressed no willingness to share in the attorney fees incurred by Defendant to obtain the settlement, (2) Plaintiff failed to act responsibly and promptly in protecting its reimbursement interest during the pre-suit negotiation process, and (3) there is no separate and distinct fund to which the settlement proceeds can be traced as required by Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356 (2006).

Defendant's first argument is foreclosed by the Supreme Court 's recent decision in McCutchen. There, an employer sponsor of a health benefit plan filed suit under 29 U.S.C. § 1132(a)(3)(B) against a plan beneficiary who was injured in a car accident, received medical benefits from the plan, and later recovered money from third parties. McCutchen, 133 S. Ct. 1537 at 1543. The employer relied on a reimbursement clause as obligating the beneficiary to reimburse the plan "any monies recovered from [a] third party." Id. The beneficiary asserted equitable defenses, arguing that, under 29 U.S.C. § 1132(a)(3), such defenses trumped the reimbursement clause. Id. at 1545. The Supreme Court rejected this argument, holding that neither of the asserted equitable defenses—the double-recovery and common-fund doctrines—could "override the clear terms of a plan." Id. at 1543. The Court reasoned that since the ERISA plan documents were, in effect, a contract documenting the "expressed commitments" of the parties, that "when parties demand what they bargained for in a valid agreement," one of the parties cannot then ignore the plain language of the agreement by applying equitable defenses. Id. at 1546.

The Supreme Court went on to find, however, that an ambiguity in the plan about the allocation of attorney's

fees left "space for the common-fund rule to operate." Id. at 1549. The reimbursement provision gave the employer the first claim on "any monies recovered from [the] third party," and the Supreme Court found "recovered" ambiguous in that it could refer to a "recovery to which [the employer] has first claim [to] every cent the third party paid or, instead, the money the beneficiary took away" after deducting the costs of recovery, including attorney fees. Id at 1549-50. Based on this ambiguity, the Supreme Court found that "the common-fund rule informs interpretation of [the] reimbursement provision," and construed "recovered" to mean the beneficiary's net recovery, after deducting attorney fees. Id. at 1551. In sum, the McCutchen Court held that equitable principles cannot trump the clear language of an ERISA plan; such principles may only be used to fill in the gaps in the event of ambiguous or absent plan terms.

Here, the terms of the Plan expressly foreclose application of the make-whole doctrine, a variant of the double-recovery doctrine at issue in McCutchen.[1] In relevant part, the SPD states:

> The Plan has a right to first reimbursement out of any recovery. Acceptance of benefits from the

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[1] Under the make-whole doctrine, if an insured receives recovery for the same loss from more than one source, i.e., an insurer and a tortfeasor, it is only after the insured has been fully compensated for al l of the loss that the insurer acquires a right to subrogation. 16 Couch on Ins. § 223:134. As noted in McCutchen, the make-whole doctrine is a variant of the double-recovery rule, which limits an insurer's reimbursement to the share of settlement proceeds paying for medical expenses, with the insured keeping the rest to cover, for example, damages for loss of future earnings or pain and suffering. McCutchen, 133 S.Ct. at 1545-46.

> Plan for an injury or illness by a covered person, without any further action by the Plan and/or the covered person, constitutes an agreement that any amounts recovered from another party by award, judgment, settlement or otherwise, and regardless of how the proceeds are characterized, *will promptly be applied first to reimburse the Plan in full for benefits advanced* by the Plan due to the injury or illness and *without reduction for attorneys' fees, costs, expenses or damages* claimed by the covered person, and *regardless of whether the covered person is made whole* or recovers only part of his/her damages.

(DE 36-4 at 26) (emphasis added). Unlike in McCutchen, this provision is unambiguous: a Plan beneficiary's receipt of a third-party recovery triggers the beneficiary's responsibility to first reimburse "in full for benefits advanced by the Plan without reduction for attorney fees and regardless of whether the covered person is made whole." In view of this plain language, the make-whole doctrine does not apply.

Importantly, the Court is not being called on to consider how the Plan's reimbursement provision would operate if the debt owed to the Plan exceeded the third-party settlement amount. As such, the concern in McCutchen about discouraging injured beneficiaries from pursuing compensation is not present here because Defendant's settlement left an amount that-even after deducting all applicable attorney fees-readily exceeds the amount sought by the Plan as reimbursement. Compare DE 39-2 at 4-5 (settlement disbursement sheet showing that Defendant spent $200,000 in attorney fees (representing a 40% contingency fee) to secure his $500,000, leaving a real recovery of $300,000—well over the $121,044.02 sought by the Plan) with McCutchen, 133

S. Ct. at 1551 (beneficiary spent $44,000 (representing a 40% contingency fee) to get $110,000, leaving a real recovery of $66,000-less than the $66,866 sought by the employer, leading the Supreme Court to conclude that absent application of the common-fund rule, "the beneficiary is made worse off by pursuing a third party . . [W]e doubt if even [the employer] would want [that result]").

As a second argument, Defendant contends that reimbursement is not appropriate because the Plan failed to verify compliance with ERISA's anti-inurement provisions as requested by defense counsel in pre-suit communications and because the Plan unduly delayed in filing suit or otherwise taking steps to protect its reimbursement interest. As Plaintiff notes, this argument sounds in laches. To prove the equitable defense of laches, a defendant must show: (1) a delay in asserting a right or a claim; (2) that the delay was not excusable; and (3) that there was undue prejudice to the party against whom the claim is asserted. Kason Indus., Inc. v. Component Hardware Group, Inc., 120 F.3d 1199, 1203 (11th Cir. 1997).

The Court is unaware of any authority, and Defendant has cited none, that provides a basis to conclude that any failure by Plaintiff to verify anti-inurement information during the pre- suit negotiation process or that Plaintiff s timeframe for filing suit was unreasonable, inexcusable or prejudicial. There is no dispute that the parties, through counsel, exchanged a series of pre- suit communications for approximately eight months after Defendant received the settlement proceeds in an attempt to resolve Plaintiff's claim for reimbursement. There is also no dispute that Plaintiff filed suit against Defendant six months after the parties exchanged final settlement offers. And since ERISA

does not specify a limitations period for a fiduciary's action to enforce a reimbursement provision, this Court is guided by Florida's five-year statute of limitations for breach of written contract actions. See Blue Cross & Blue Shield of Alabama v. Sanders, 138 F.3d 1347, 1356 (11th Cir. 1998)(the forum state's statute of limitations for a simple contract action applies in an ERISA fiduciary's suit for reimbursement because "[i]n an ERISA action with no congressionally mandated limitations period, the district court must define the essential nature of the ERISA action and apply the forum state's statute of limitations for the most closely analogous action"); Fla. Stat. § 95.11(2)(b). In view of the undisputed facts, the absence of authority to support Defendant's position, and Florida's five-year statute of limitations for closely analogous breach of contract actions, the Court rejects this second argument.

As a third and final argument, Defendant contends that the relief sought by Plaintiff is inappropriate because the settlement funds have been dissipated and, as such, the Plan cannot identify a fund separate and distinct from the Defendant's general assets as is required by Sereboff. In support, Defendant submits a settlement disbursement sheet showing payments made out of the $500,000 settlement proceeds, including for attorney fees, costs, medical expenses, and satisfaction of a wide variety of liens (DE 39-3, Montanile Aff. Ex. A).[2]

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[2] Because the Court ultimately finds that any dissipation of settlement funds by Defendant is immaterial, the Court does not reach the parties' varying interpretations of this settlement disbursement sheet. The Court notes, however, that the sheet raises more questions than answers. For instance, it contains no dates for the various line-item disbursements and includes what appears to be erroneous calculations (the "Less: Medical expenses line" lists a deduction for "$1,213.22" but the listed medical expenses of $465.22,

(continued ...)

Defendant has also submitted an affidavit stating that after making the foregoing payments, "approximately $90,000" remained, most of which Defendant has "spent since the time of the settlement in supporting [him]self and his daughter and in maintaining our home" (DE 39-3, Montanile Aff. ¶ 6).

In recent times, the Supreme Court has twice addressed the issue of what qualifies as "appropriate equitable relief" under ERISA, 29 U.S.C. § 1132(a)(3). In Great-West Life & Annuity Ins . Co . v. Knudson, 534 U.S. 204 (2002), the Supreme Court found that, because a fiduciary sought reimbursement of funds that were not in a beneficiary's possession but had instead been placed in a "Special Needs Trust" under California law, it was seeking "in essence, to impose personal liability on [the beneficiary] for a contractual obligation to pay money-relief that was not typically available in equity." Id. at 214. The Knudson Court's rationale rested on the form of restitution sought by the fiduciary-a money judgment from undifferentiated assets of the beneficiary; because such action is classified as "legal" rather than "equitable," the fiduciary's claim was not one for which ERISA provided a remedy . Id. at 218 .

The Supreme Court later clarified this holding in Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356 (2006), which involved a plan fiduciary's suit to

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$398.00, $416.89, and $300.00 add up to $1,580.11). Defendant has supplied no other documents, such as bank statements or receipts, to establish the settlement fund disbursement history. Also noteworthy is Plaintiff's unchallenged statement that the "Blue Cross Blue Shield/Health Care Lien" for "$108,607.07" actually represents an amount "withheld from settlement to satisfy Plaintiff's reimbursement claim . . ." (DE 41 at 7).

enforce plan terms for reimbursement out of a beneficiary's post-accident settlement proceeds. The Court explained that as long as a plan fiduciary seeks "its recovery through a constructive trust or equitable lien on a specifically identified fund, not from the [beneficiaries'] assets generally," the claim is equitable in nature. Id. at 363. Applying that principle, the Sereboff Court held that the "specifically identified fund" was the "recover[y] from a third party (whether by lawsuit, settlement or otherwise)" and that the "particular share of that fund to which [the fiduciary] was entitled was the portion of the total recovery which is due for benefits paid." Id. at 364.

The settlement funds in Sereboff had been paid directly to beneficiaries who agreed to hold the funds in a separate account to avoid commingling of assets until the litigation resolved. Id. at 360. Thus, the Supreme Court held , the fiduciaries sought recovery of particularly identifiable funds in the beneficiaries' possession, and the impediment to recovery in Knudson did not exist. Id. at 362-63. Moreover, the plan's reimbursement provisions created an "equitable lien by agreement" on any future recovery by the beneficiary for the same injury; i.e., the settlement funds. Id. at 363. In support of its analysis, the Sereboff Court relied on a century-old case for the proposition that the fiduciary did not have to trace the property back to its own possession in order to assert the lien based on the "familiar rul[e] of equity that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing." Id. at 364-65, 367 (quoting Barnes v. Alexander, 232 U.S. 117, 121 (1914)).

Of particular significance in the present case is Sereboff's rejection of an argument that the fiduciary's claim was not equitable because equitable restitution

requires a strict tracing of the tainted assets. First, the Court distinguished equitable restitution from equitable liens by agreement and affirmed that Barnes places no similar tracing requirement on the latter type of claim. Id. at 365. The Sereboff Court also refused to hold that Knudson crafted a new tracing requirement because Knudson described only "in general terms" a fiduciary's right to recover equitable restitution, and "[t]here was no need in Knudson to catalog all the circumstances in which equitable liens were available in equity. " Id. at 365. Neither Knudson nor Sereboff, in other words, exhaust the universe of "appropriate equitable relief," so long as both the claim and the relief sought sound in equity.

Following Knudson and Sereboff circuit courts—including the Eleventh-have enforced ERISA plan reimbursement provisions against third parties holding tort settlement funds achieved by plan beneficiaries. Constructive trusts have been imposed to enforce a plan's equitable lien by agreement on settlement proceeds held by a beneficiary's tort lawyer, Longaberger v. Kolt, 586 F.3d 459 (6th Cir. 2009); by a trustee of a beneficiary's wife's special needs trust, Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Shank, 500 F.3d 834 (8th Cir. 2007); and by a mom serving as conservator for her teenage son. Admin. Comm. for Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Horton, 513 F.3d 1223 (11th Cir. 2008). In each of these cases, the courts held that, under Knudson and Sereboff, an equitable lien for reimbursement attached to settlement proceeds as soon as a settlement fund arose from the injuries requiring plan payments. See, e.g. Longaberger, 586 F.3d at 467.

As stated by the Eleventh Circuit:

> Where property is held by one person upon a constructive trust for another, and the former transfers the property to a third person who is not a bona fide purchaser, the interest of the beneficiary is not cut off. In such a case, he can maintain a suit in equity to recover the property from the third person, at least if his remedies at law are not adequate.

Horton, 513 F.3d at 1223 (quoting Restatement of Restitution § 160 cmt. g (1937)). The Horton court went on to conclude that:

> In the instant case, the Administrative Committee properly seeks equitable restitution of a specifically identifiable fund in possession of a defendant. As required by Knudson, the [Plan] asserts title and right to possession of particular property that is in the hands of Mrs. Werber in her capacity as Joshua's conservator. The money Mrs. Werber holds in trust has been identified as belonging in good conscience to the [Plan] by virtue of the Plan's terms, and the money can clearly be traced to a particular fund in the defendant's possession. The fact that Mrs. Werber holds the funds as a third party does not defeat the [Plan's] claim. Under Knudson, Sereboff, and the other authorities cited above, the most important consideration is not the identity of the defendant, but rather that the settlement proceeds are still intact, and thus constitute an identifiable res that can be restored to its rightful recipient. Had the Administrative Committee solely sued parties not in possession of the disputed funds, the claim would have failed under Knudson because it merely would have sought to impose personal liability on those parties.

Id. at 1228-29.

Importantly, Sereboff did not address the issue of a beneficiary's dissipation of assets because the funds there were placed in a separate account throughout the duration of the case. The Eleventh Circuit has similarly not had occasion to address this issue of dissipation. However, the overwhelming majority of circuit courts to have done so have held, after interpreting Sereboff, that a beneficiary's dissipation of assets is immaterial when a fiduciary asserts an equitable lien by agreement. See Cusson v. Liberty Life Assurance Co. of Bos., 592 F.3d 215, 231 (1st Cir. 2010) (an ERISA plan administrator need not identify a "specific account in which the funds are kept or prove[ ] that they are still in [the beneficiary's] possession"); Thurber v. Aetna Life Ins. Co., 712 F.3d 654, 664 (2d Cir. 2013)("[I]n the context of an equitable lien by agreement, rather than an equitable lien sought as a matter of restitution, all that matters is that the beneficiary did, at some point, have possession and control of the specific portion of the particular fund sought by the insurer."); Funk v . CIGNA Grp. Ins., 648 F.3d 182, 194-95 (3d Cir. 2011)("dissipation of the funds [is] immaterial" if an equitable lien by agreement is in place); ACS Recovery Servs., Inc . v . Griffin, 723 F.3d 518, 526 (5th Cir. 2013) cert. denied, 134 S. Ct. 618 (2013)(employee need not have possession and control of funds for ERISA plan fiduciaries to seek recovery); Longaberger Co. v. Kolt, 586 F.3d 459, 466 (6th Cir. 2009)("[A]n equitable lien by agreement does not require tracing or maintenance of a fund in order for equity to allow repayment."); Gutta v. Standard Select Trust Ins. Plans, 530 F.3d 614, 621 (7th Cir. 2008)(equitable lien by agreement "is not dependent on the ability to trace particular funds [and group disability insurer] may bring its counterclaim under 29 U.S.C. § 1132(a)(3) even if the benefits it paid [the beneficiary] are not specifically

traceable to [the beneficiary's] current assets because of commingling or dissipation "); but see Bilyeu v. Morgan Stanley Long Term Disability Plan, 683 F.3d 1083, 1093-95 (9th Cir. 2012)("Nothing in Sereboff suggests that a fiduciary can enforce an equitable lien against a beneficiary 's general assets when specifically identified funds are no longer in a beneficiary's possession.").

Following the majority view, the Court concludes that any dissipation of the settlement funds by Defendant is immaterial. The present case is analogous to Sereboff in that an operative Plan provision clearly provides that the Plan is entitled to the reimbursement of benefits paid out in the event of a beneficiary's recovery from a third party: "The Plan has the right to recover benefits advanced by the Plan to a covered person for expenses or losses caused by another party." (DE 36-4 at 26). Further, "[t]he Plan has a right to first reimbursement out of any recovery " and "[a]cceptance of benefits from the Plan for an injury or illness by a covered person, without any further action by the Plan and/or the covered person, constitutes an agreement that any amounts recovered from another party by award, judgment, settlement or otherwise, and regardless of how the proceeds are characterized, will promptly be applied first to reimburse the Plan in full for benefits advanced by the Plan " (Id.). These provisions put Defendant on clear notice that any third-party recovery he received "by award, judgment, settlement or otherwise" belonged, as a matter of first right, to the Plan. By virtue of this clear pre-existing agreement, an equitable lien by agreement arose for the benefit of Plaintiff when Defendant obtained the third-party settlement under which he would receive monetary compensation for his accident-related injuries. In other words, Defendant's right to receive money from the settlement immediately became subordinate to the

Plan's lien. The settlement proceeds represent an identifiable fund to which the Plan's lien attached and such proceeds belong "in good conscience" to the Plan to the extent of the medical expenses it paid on Defendant's behalf. Such a conclusion is entirely consistent with the rationale of Sereboff and the "familiar rul[e] of equity" recited therein.

The Plan actively pursued its right to reimbursement first through a pre-suit process of negotiation and then—when that process proved unsuccessful—by filing this ERISA suit. That Defendant may have dissipated the funds over which Plaintiff holds a valid equitable lien by agreement is insufficient to void Plaintiff's right to enforce the reimbursement provision and the resulting equitable lien by agreement in Plaintiff's favor. See Funk, 648 F.3d at 194 (if "there was an equitable lien by agreement that attached to the [third-party benefits] as soon as [the beneficiary] received it, dissipation of the funds [is] immaterial").

Defendant argues that the Court should follow decisions out of the Middle District of Florida that run contrary to the majority of case law interpreting Sereboff in the context of an ERISA beneficiary's dissipation of assets. See, e.g., Jones v. Fed. Exp. Corp., 2013 WL 6038734 (M.D. Fla. Nov. 14, 2013); Epolito v. Prudential Ins. Co. of Am., 737 F.Supp.2d 1364 (M.D. Fla. 2010); Herman v. Met. Life Ins. Co., 689 F.Supp.2d 1316 (M.D. Fla. 2010). The Court respectfully disagrees with these decisions, which generally subscribe to the view espoused in Knudson that the dissipation of property such that "no product remains" means that a plaintiff cannot enforce an equitable lien upon other property of the defendant as such plaintiff's claim is only that of a general creditor. Jones, 2013 WL 6038734 at *25. Citing post-Sereboff Eleventh Circuit precedent for

the proposition that "equitable relief under ERISA continues to require that the fiduciary identify specific assets still in the possession of the beneficiary[,]" these decisions conclude that a requirement of extant and identifiable specific property maintains a proper distinction "between equitable restitution and a money judgment." Id. at *22-23, 26 (citing Green v. Holland, 480 F.3d 1216, 1225-26 (11th Cir. 2007); Horton, 513 F.3d at 1226-27).

While reasonable jurists can certainly disagree on this issue, the Court is unpersuaded by the above Middle District of Florida decisions as they relate to dissipation of assets. As recognized by the Eleventh Circuit, Sereboff emphasized that the funds in issue "had been specifically identified (via the third party recovery provision of the plan itself); that the funds were still in the defendant's possession; and that it was undisputed that the plaintiff was entitled to them under the plan 's terms." Holland, 480 F.3d at 1225 (citing Sereboff, 547 U.S. at 362- 63). Here, the funds in issue have been specifically identified (via the provisions providing for Plaintiff's right to be reimbursed out of any third party recovery) in a specific amount ($121,044.02) as authorized by the Plan. These funds were entrusted first to Defendant's counsel, then to Defendant.

This Court's departure from the analysis in the Middle District of Florida cases turns on the requirement that the funds "still be in the defendant's possession." To conclude that Defendant's post-settlement dissipation of funds would defeat Plaintiff's reimbursement claim would be to wholly ignore the rationale of Sereboff. Without Defendant's injury, there would have been no Plan payments for his medical expenses or the later settlement. As discussed above, when Defendant agreed to the third-party settlement

under which he would receive monetary compensation for his accident-related injuries, an equitable lien by agreement arose for the benefit of Plaintiff. The settlement proceeds represent an identifiable fund originally within the Defendant's possession to which the Plan's lien has attached and such lien is not dependent on the ability to trace the funds in real-time. To hold otherwise "would make § 1132(a)(3)(B)(ii) an empty promise" based on the important principle that "ERISA provides for equitable remedies *to enforce plan terms.*" Sereboff, 547 U.S. at 363 (emphasis in original). To hold otherwise would also open the door to the type of "outrageous" conduct recently censured by the Seventh Circuit, to wit, dissipation of settlement proceeds by a lawyer and client in knowing and willful ignorance of an ERISA plan's lien against the settlement proceeds. Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Lewis, 2014 WL 943412, *4 (7th Cir. Mar. 12, 2014).

IV. CONCLUSION

Based on the foregoing, the Court concludes that Plaintiff has a right under Summary Plan Description's "Other Party Liability Claims" provision to seek reimbursement for the monies it paid to cover Defendant's medical expenses arising from his 2008 car accident, for which Defendant has obtained a third-party settlement. The Court further concludes that such reimbursement constitutes "appropriate equitable relief" within the meaning of ERISA, 29 U.S.C. § 1132(a)(3)(B).

Accordingly, the Court ORDERS that Plaintiff s Motion for Summary Judgment (DE 36) is GRANTED, and Defendant's Motion for Summary Judgment (DE 35) is DENIED. Pursuant to Federal Rule of Civil Procedure 58(a), the court will enter a Final Judgment by separate order.

DONE and ORDERED in Chambers at West Palm Beach in the Southern District of Florida, this 17th day of March, 2014.

DAVE LEE BRANNON
U.S. MAGISTRATE JUDGE

APPENDIX C

PRECEDENTIAL

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

Nos. 13-11738 & 13-14912

AIRTRAN AIRWAYS, INC.,

Plaintiff-Appellee,

v.

BRENDA ELEM, MARK D. LINK, and LINK & SMITH, P.C.,

Defendants-Appellants.

On Appeal from the United States District Court
for the Northern District of Georgia
D.C. Civil Action No. 1:10-cv-03673-ODE

Before: WILLIAM PRYOR and MARCUS, *Circuit Judges*, and HONEYWELL,* *District Judge*.

Filed: September 23, 2014

* Honorable Charlene Edwards Honeywell, United States District Judge for the Middle District of Florida, sitting by designation.

OPINION OF THE COURT

PRYOR, *Circuit Judge.*

This appeal requires us to decide whether an employee welfare benefit plan may recover medical costs it spent on behalf of a beneficiary after she and her attorney conspired to hide and disburse settlement funds she received after a car accident. Brenda Elem participated, as an employee of AirTran, in a self-funded employee welfare benefit plan. After Elem suffered injuries in a car accident and the plan paid over $100,000 for her medical care, Elem sued the other driver and settled for $500,000. AirTran sought reimbursement from Elem, but Elem's attorney, Mark Link, misrepresented that Elem had settled for only $25,000. Link's sin then found him out, *see* Numbers 32:23, when he accidentally sent the plan a copy of a settlement check for $475,000. After AirTran sued Elem, Link, and Link & Smith, P.C., for violations of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1132(a)(3), the district court granted summary judgment and awarded attorney's fees and costs in favor of AirTran.

Elem, Link, and the law firm challenge three orders. They contest the summary judgment on the ground that AirTran failed to satisfy the strict tracing rules of equitable restitution, but these rules do not apply to the equitable lien by agreement that the AirTran plan created. *See Sereboff v. Mid Atlantic Med. Serv., Inc.*, 547 U.S. 356, 364–65, 126 S. Ct. 1869, 1875 (2006). Elem and Link argue that the district court abused its discretion when it awarded AirTran attorney's fees and costs, but the district court had the authority to sanction them for their bad faith. Elem and Link also complain that the district court misapplied Federal Rule of Civil Procedure

70 when the court ordered enforcement of the judgment, but that issue became moot when Link and his law firm complied with the order. We affirm the summary judgment and award of fees and costs and dismiss as moot the appeal of the order to enforce the judgment.

I. BACKGROUND

In 2007, Brenda Elem sustained injuries in a car accident. Her employer, AirTran, paid $131,704.28 for her medical care as a result of her participation in its self-funded employee welfare benefit plan. The plan designated Elem as a constructive trustee over any payments recovered from third parties and created an equitable lien for the amount of benefits paid by the plan. Under the plan, when Elem accepted her medical benefits from AirTran, she acknowledged that AirTran had a first priority claim to all payments made by a third party, even if that third party failed to pay the full amount of her damages. Months after the accident, the plan administrator advised Elem that, if she sued the driver of the other vehicle, Migel Rizo, the terms of the plan required Elem to reimburse AirTran with proceeds from that suit. And the plan administrator also advised Rizo's insurer, AIG, of that right to reimbursement.

In September 2007, when Elem contacted AIG to settle the claim against Rizo within his liability policy limits of $25,000, she misrepresented that the plan would have no lien against any funds she would recover from AIG. She also stated that she intended to sue Rizo for the full amount of her damages if AIG refused to pay the $25,000. AIG responded that Rizo's policy limit was $25,000 and that it would be willing to issue a settlement check for that amount to Elem if her plan "waive[d] their

subrogation lien" or to Elem and the plan if the plan did not waive the lien.

Elem hired Mark Link of Link & Smith, P.C., as her attorney and sued Rizo for the injuries she sustained in the accident. AIG advised Link that it had offered

$25,000 to Elem, but that AIG had notice of a lien and a duty to protect its insured. In December 2007, the plan administrator for AirTran notified Link of the lien in favor of AirTran.

Rizo and Elem later settled their lawsuit for $500,000. During the negotiation of their settlement agreement, Link asked AIG to prepare two releases: one reflecting payment of the policy limit of $25,000 and another for $475,000 in settlement of Rizo's claim of bad faith. Link also requested two separate checks and demanded that the $25,000 release not mention Rizo's release of his claim of bad faith. AIG responded that "it seems deceptive" to omit Rizo's release of his claim, but Link got his way.

Elem executed a release in favor of AIG for $25,000 and another release for $475,000 signed also by Rizo. AIG issued two separate settlement checks to Elem, Link, and Link & Smith, one for $25,000 and another for $475,000. Elem later received $274,184.08; Link & Smith retained $190,000.00 for attorney's fees and $10,815.92 for expenses; and Link & Smith kept the remaining funds of $4,500.00 in an escrow account.

When Link informed the plan administrator about the settlement, he stated that Elem had settled her claim against Rizo for the policy limit of $25,000 and "has abandoned any hope of recovering" more than that amount. Although Link intended to enclose a copy of the $25,000 check as proof of that settlement, he

inadvertently enclosed a copy of the $475,000 check. The plan administrator noticed the error and demanded reimbursement from "[a]ll [s]ettlements and [j]udgments."

When Elem refused to reimburse the plan, AirTran filed suit against Elem, Link, and Link & Smith. The parties filed cross motions for summary judgment, and the district court granted summary judgment in favor of AirTran. The court then awarded AirTran attorney's fees in the amount of $145,723.28 and costs in the amount of $3,692.52.

When Link still refused to pay, AirTran filed a motion to enforce the judgment under Federal Rule of Civil Procedure 70. Elem and Link responded that Rule 70 was inapplicable because the judgment against them was for money damages enforceable only through a writ of execution. The district court granted the motion and ordered Elem and Link to satisfy the full amount of the judgment or post a bond. AirTran later moved to hold Elem and Link in contempt when they refused to comply with the order, but AirTran withdrew the motion when Link and Link & Smith eventually paid the full amount of the judgment and attorney's fees and costs. At oral argument, the parties stipulated that Link and his firm conditioned this payment on the disposition of the appeal of the summary judgment and the award of attorney's fees and costs.

II. STANDARDS OF REVIEW

Two standards of review govern us. First, we review *de novo* a summary judgment and draw all inferences and review all evidence in the light most favorable to the nonmoving party. *Hamilton v. Southland Christian Sch., Inc.*, 680 F.3d 1316, 1318 (11th Cir. 2012). Summary

judgment should be granted only when the movant establishes that there is no genuine issue of material fact and that the movant is entitled to judgment as a matter of law. *Id.* We also review the mootness of an appeal *de novo*. *Tanner Adver. Grp., L.L.C. v. Fayette Cnty., Ga.*, 451 F.3d 777, 784 (11th Cir. 2006). Second, we review for abuse of discretion an award of attorney's fees and costs. *Byars v. Coca-Cola Co.*, 517 F.3d 1256, 1263 (11th Cir. 2008).

III. DISCUSSION

Elem and Link contest the summary judgment in favor of AirTran, the award of fees and costs, and the issuance of the Rule 70 order to enforce the judgment, but their arguments fail. We discuss each order of the district court in turn.

A. The District Court Correctly Granted Summary Judgment in Favor of AirTran.

We divide this section in two parts. We first discuss Elem and Link's challenge to the summary judgment in favor of AirTran on the ground that AirTran failed to seek equitable relief. We second discuss Elem and Link's attempts to avoid liability based on four technicalities, none of which justify the breach of their fiduciary duty.

1. AirTran seeks appropriate equitable redress.

The Act permits AirTran to file a civil action "to obtain . appropriate equitable relief . . to redress" the misdeeds of Elem, Link, and Link & Smith. 29 U.S.C. § 1132(a)(3) (B). "[A]ppropriate equitable relief" includes only "those categories of relief that were *typically* available in equity," *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210, 122 S. Ct. 708, 712 (2002). Elem and Link argue that AirTran cannot recover Elem's medical costs because AirTran seeks money damages, a legal remedy, but AirTran contends that the

plan created an equitable lien by agreement over the settlement funds. AirTran argues that it seeks to recover "specifically identifiable funds" in "the possession and control" of Elem and Link, that the plan created an equitable lien by agreement, and that its claim, therefore, falls within "appropriate equitable relief" allowed under the Act. *Sereboff*, 547 U.S. at 362–63, 126 S. Ct. at 1874 (internal quotation marks omitted).

This case sounds in equity. When AirTran filed suit against Elem and Link, it did so to enforce the equitable lien by agreement created by the plan. In "the days of the divided bench," this suit would have been equitable in nature. *See id.* at 363–65, 126 S. Ct. at 1874–76. Like the plan in *Sereboff*, the unambiguous terms of the AirTran plan created an equitable lien against any settlement funds that Elem received as a result of her accident. As soon as AIG gave Elem the settlement funds, AirTran "could follow it into the hands of [Elem and Link]." *Barnes v. Alexander*, 232 U.S. 117, 123, 34 S. Ct. 276, 278 (1914).

We must also ensure that the nature of the remedy AirTran seeks is equitable. *Compare Sereboff*, 547 U.S. at 361–63, 126 S. Ct. at 1873–74, *with Knudson*, 534 U.S. at 212–14, 122 S. Ct. at 714–15. Elem and Link are correct that the remedy of money damages is quintessentially a remedy at law. For that reason, a plan may not file suit against a beneficiary for reimbursement and seek recovery from "assets generally" of that beneficiary, because that suit would seek legal, not equitable, restitution. *Sereboff*, 547 U.S. at 363, 126 S. Ct. at 1874 (distinguishing *Knudson*). But when a plan seeks "specifically identifiable funds" in "the possession and control" of a beneficiary, such restitution of the funds is

equitable in nature. *Id.* at 362–63, 126 S. Ct. at 1874 (internal quotation marks omitted).

AirTran seeks an equitable remedy. AirTran filed suit to enforce its equitable lien over "specifically identifiable funds" that Elem had in her "possession." *See Sereboff*, 547 U.S. at 362–63, 126 S. Ct. at 1874 (internal quotation marks omitted). According to the plain terms of the plan, the settlement that AIG paid to Elem constitutes the specifically identifiable funds over which AirTran had a lien. Elem and Link attempt to liken those settlement funds to the funds in *Knudson*, but, unlike the beneficiary in *Knudson*, Elem possessed the funds. *Id.* (distinguishing *Knudson* on the ground that the beneficiary never possessed the settlement fund); *see also Thurber v. Aetna Life Ins. Co.*, 712 F.3d 654, 664 (2d Cir. 2013) ("[A]ll that matters is that the beneficiary did, at some point, have possession and control of the specific portion of the particular fund sought by the insurer."). Once she possessed those funds, the equitable lien by agreement attached to them, making them "specifically identifiable." *Sereboff*, 547 U.S. at 362–63, 126 S. Ct. at 1874.

We disagree with our dissenting colleague, who adopts the position of the Ninth Circuit and concludes that AirTran cannot collect what it is owed because it has not traced the settlement funds after Elem divided them with her attorney. (Dissenting Op. at 30–33). *See Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083, 1095 (9th Cir. 2012) ("Nothing in *Sereboff* suggests that a fiduciary can enforce an equitable lien against a beneficiary's *general assets* when specifically identified funds are no longer in a beneficiary's possession."). It matters not whether the settlement funds have since been disbursed or commingled with other funds. In *Sereboff*, the Supreme Court made clear

that AirTran need not trace the settlement fund back to AirTran to enforce its equitable lien by agreement. *Id.* at 364–65, 126 S. Ct. at 1875–76. As soon as the settlement fund was identified, the plan imposed an equitable lien over that fund even though it was in the hands of the beneficiaries. *Id.* at 363–64, 126 S. Ct. at 1875. And in the wake of *Sereboff*, our sister circuits have concluded that "[p]roperty to which the lien attached may be converted into other property without affecting the efficacy of the lien." *Funk v. CIGNA Grp. Ins.*, 648 F.3d 182, 194 (3d Cir. 2011); *see Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Lewis*, 745 F.3d 283, 285 (7th Cir. 2014) ("The defendants argued . . that because the settlement funds have been dissipated, this really is a suit for damages . But the defendants are wrong."); *Thurber*, 712 F.3d at 663–64 ("[T]he beneficiary's literal segregation of funds is irrelevant when the terms of the plan put the beneficiary on notice that she would be required to reimburse the insurer for an amount equal to what she might get from third-party sources." (alterations and internal quotation marks omitted)); *Cusson v. Liberty Life Assurance Co. of Boston*, 592 F.3d 215, 231 (1st Cir. 2010); *Longaberger Co. v. Kolt*, 586 F.3d 459, 466–67 (6th Cir. 2009); *see also Popowski v. Parrott*, 461 F.3d 1367, 1374 n.8 (11th Cir. 2006) ("[T]he fact that the third-party recovery triggering the [p]lan's reimbursement provision was comingled, even absent tracing, would not have disqualified an equitable lien had that equitable lien been *by agreement* "). We join those circuit courts and conclude that, even though Elem willfully refused to abide by the terms of the AirTran plan, her dereliction as a constructive trustee could not destroy the lien that attached *before* Elem divided the funds with her attorney. *See Barnes*, 232 at 122, 34 S. Ct. at 278

(explaining that the lien often attaches before the specific funds exist). Elem and Link argue that AirTran may take only the remaining $4,500 of settlement funds left in the escrow account, but they misunderstand that the plan imposed a lien for the entire $131,704.28 of medical benefits paid, which attached when Elem obtained the settlement funds. Contrary to Elem and Link's argument, these "specifically identifiable funds" did not disappear when they divided the money.

By the terms of the plan, AirTran paid for Elem's medical care and, as a result, could enforce it the moment Elem possessed the settlement checks from AIG. Even though Elem and Link distributed the funds, the *res* remained the same: the amount of the medical benefits paid to Elem. *See Barnes*, 232 U.S. at 122, 34 S.Ct. at 278. Elem and Link cannot defeat the first priority lien of AirTran, and Elem cannot abandon her duties as trustee under the constructive trust by commingling the *res* with other funds. *See Gutta v. Standard Select Trust Ins. Plans*, 530 F.3d 614, 621 (7th Cir. 2008) ("[The insurer] may bring its counterclaim [for reimbursement] even if the benefits it paid Gutta are not specifically traceable to Gutta's current assets because of commingling or dissipation."). Their dishonesty and manipulation of the settlement funds cannot destroy the lien of AirTran over the "specifically identifiable" monies.

2. Elem and Link's remaining arguments about the summary judgment are meritless.

Elem and Link raise four additional arguments, none of which we find persuasive. First, Link and Link & Smith argue that AirTran cannot recover from them as third-party attorneys. Second, Elem and Link argue that, when AIG funded the $475,000 portion of the settlement, AIG no longer qualified as a "responsible party" under

the plan. Third, they argue that AirTran cannot force Elem to reimburse it because AirTran never disclosed to her the plan terms. Fourth, Elem seeks to avoid liability by arguing that, because the plan administrator provided healthcare services, AirTran cannot sue to enforce its right to reimbursement. We address each of these arguments in turn.

Link and Link & Smith argue that they are not proper defendants because AirTran cannot seek reimbursement from a third-party attorney, but that argument fails. A plan may recover from a nonfiduciary party in interest, even if that party has not violated a duty expressly imposed by the Act. *Harris Trust & Sav. Bank v. Saloman Smith Barney, Inc.*, 530 U.S. 238, 245, 120 S. Ct. 2180, 2186–87 (2000). Because Elem breached her fiduciary duty as trustee and transferred the trust property to Link and Link & Smith, the attorneys took the property subject to the trust, unless they purchased the property for value and without notice of the fiduciary's breach of duty. *Id.* at 250, 120 S. Ct. at 2189. Even if Link and Link & Smith were not the original wrongdoers, they are not insulated from liability for restitution. *Id.* at 251, 120 S. Ct. at 2189; *see also Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough*, 354 F.3d 348, 357–58 (5th Cir. 2003), *abrogated on other grounds*, *ACS Recovery Serv., Inc. v. Griffin*, 723 F.3d 518 (5th Cir. 2013) (en banc). And Link and Link & Smith are hardly innocent parties. Link and his firm tried to hide the full amount of the settlement agreement from AirTran. Link represented that the $25,000 would take care of any liens on the settlement asserted by AirTran, but paid himself and his firm $200,815.92. Even if they had not known of the first priority lien of AirTran, they could not defeat the lien, but the record makes clear that the plan

administrator had repeatedly notified Link and Link & Smith that AirTran had an equitable lien and intended to enforce it.

Link and his firm knew that they took fees and costs subject to the lien held by AirTran, and they cannot now avoid liability by asserting that they did not agree to the terms of the plan. The lien arose before they entered into a contingency fee arrangement with Elem, and Elem agreed to the terms of the plan long ago. She agreed that "[t]he Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by [Elem] to pursue [Elem]'s damage claim." These obligations, which "precluded [Elem] from contracting away to the law firm that which [she] did not own [herself], namely, the right to all or any portion of the [sum] that rightfully belonged to the Plan," predated her attorney-client relationship with Link and his firm. *Bombardier*, 354 F.3d at 357. That Link and his firm disregarded the first priority lien of AirTran and commingled the settlement funds does not defeat the claim for equitable relief by AirTran because, "under *Sereboff*, [AirTran] was free to follow a portion of the settlement funds into [Link and Link & Smith's] hands." *Longaberger Co.*, 586 F.3d at 469.

Elem and Link argue too that Elem could not have wrongfully transferred the settlement funds because Elem never had "possession" of those funds. They explain that AIG transferred the funds to Link and his firm. They argue that, because Elem never possessed the funds, her duty to reimburse AirTran was never triggered.

Nonsense. Even if AIG wrote and delivered the checks to Link and his firm, Elem "had at least constructive possession and control of the fund[s] to facilitate the settlement." *Griffin*, 723 F.3d at 529

("Griffin's attempt to divorce himself from the origin of the fund and its disposition is no more persuasive than if he had directed the money to a close relative. [H]e could not give away that which he did not possess."). And here, Elem likely had "actual possession" because her attorney, as her agent, received and deposited the checks.

Elem and Link also argue that AirTran cannot seek reimbursement because AIG is not a "responsible party" under the terms of the plan. They argue that, when AIG paid the $475,000 check, AIG no longer qualified as a "responsible party" for the purposes of reimbursement because AIG was no longer providing "liability coverage" for Rizo, but this argument contravenes the plain terms of the plan.

The terms of the plan entitle AirTran to reimbursement from "any payment" from "any Responsible Party as a result of an injury, illness, or condition." The plan defines "Responsible Party" as "any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition[, which] includes the liability insurer of such party or any insurance coverage." Because AIG settled the lawsuit for $500,000, it meets the definition of a "responsible party." It matters not at all that Rizo's policy limits were only $25,000 because the terms of the plan allow AirTran to recover "any payment" to Elem "due to" her injury. AirTran now may seek its "specifically identifiable" amount from the $500,000 for medical expenses paid on behalf of Elem.

Elem and Link also attempt to evade liability by arguing that AirTran cannot force Elem to reimburse AirTran because she never saw the plan documents, but Elem accepted the benefits and is bound by the terms of

the plan unless AirTran prejudiced Elem by its failure to disclose them. Our Court has said that "the quantity of an employer's procedural violations," such as failure to abide by disclosure requirements, "may work a substantive harm." *Harris v. Pullman Standard, Inc.*, 809 F.2d 1495, 1499 (11th Cir. 1987). But an employee must establish that she was prejudiced by an infraction committed by the plan. *See Hein v. TechAmerica Grp., Inc.*, 17 F.3d 1278, 1280–81 (10th Cir. 1994); *see Kreutzer v. A.O. Smith Corp.*, 951 F.2d 739, 743 (7th Cir. 1991) (requiring bad faith, active concealment, or inducement to rely on a faulty plan summary by an administrator before a court will award recovery for procedural violations).

Elem has not alleged that AirTran committed a multitude of procedural violations or that she was prejudiced by any nondisclosure. Nor can she. The plan administrator repeatedly sent letters expressing its intent to pursue reimbursement. And Elem allowed AirTran to pay over $130,000 of her medical bills. Elem knew of the lien before disbursing the funds to herself and to her attorney, and she cannot avoid liability on a technicality. *See Weinreb v. Hosp. for Joint Diseases Orthopaedic Inst.*, 404 F.3d 167, 171–72 (2d Cir. 2005) ("Where a plan administrator fails to fulfill its statutory duty , but where the evidence shows that the claimant had actual knowledge of the requirement at issue, the error is necessarily harmless.").

Finally, Elem and Link argue that AirTran lacks standing to seek reimbursement of Elem's medical costs that the plan administrator paid, but they misunderstand the nature of the self-funded employee benefit plan offered by AirTran. Under the terms of the plan, AirTran provided various benefit options to its employees and contracted with the plan administrator to provide various services, including network access, subrogation, and

patient management services. In the district court, Elem relied on language in the Benefits Enrollment Guide, which refers to healthcare services provided by the plan administrator, but the provision of those administrative services does not give the plan administrator the right to seek reimbursement from Elem. Instead, AirTran still paid for all expenses incurred by its participants, including Elem. We reject Elem and Link's argument that AirTran cannot now recover its costs because it contracted with the plan administrator.

B. The District Court Did Not Abuse Its Discretion by Awarding Attorney's Fees and Costs to AirTran.

A district court, "in its discretion," may award attorney's fees to a party, 29 § 1132(g)(1), if that party achieved "some degree of success on the merits," *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 255, 130 S. Ct. 2149, 2158 (2010). We require district courts to consider five factors when deciding whether to award fees to a prevailing party:

> (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorney's fees;
>
> (3) whether an award of attorney's fees against the opposing parties would deter other persons acting under similar circumstances; (4) whether the parties requesting attorney's fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; [and] (5) the relative merits of the parties' positions.

Freeman v. Continental Ins. Co., 996 F.2d 1116, 1119 (11th Cir. 1993). We have explained that "[n]o one of these factors is necessarily decisive, but together they are

the nuclei of concerns that a court should address." *Iron Workers Local No. 272 v. Bowen*, 624 F.2d 1255, 1266 (5th Cir. 1980).

Elem and Link argue that the district court unjustly awarded AirTran attorney's fees, but the five *Freeman* factors support the award. First, we rarely see such a textbook example of "bad faith." Link intentionally attempted to deceive the plan administrator when he sent the letter stating that $25,000 represented the entire settlement amount. And he coerced AIG to draft two separate releases to effectuate his deception. Fortunately for AirTran, his scheme came crashing down when he sent a copy of the $475,000 check to the plan administrator. His actions no doubt evince bad faith. Second, Link and Link & Smith have already satisfied the award, although conditionally. Third, an award of attorney's fees in this circumstance would help deter others from cheating their employee benefit plan. Fourth, the award protects plan assets, which benefit all plan participants. And fifth, the defense mounted by AirTran was highly meritorious. The district court did not abuse its discretion when it awarded attorney's fees to AirTran.

C. The Payment of the Award of Fees and Costs Moots Any Argument About the Entry of the Rule 70 Order by the District Court.

Elem and Link argue that the district court misinterpreted Federal Rule of Civil Procedure 70 when it ordered them to pay the full amount of the judgment and fees and costs. Rule 70 provides, "If a judgment requires a party to convey land, to deliver a deed or other document, or to perform any other specific act and the party fails to comply within the time specified, the court may order the act to be done—at the disobedient party's expense—by another person appointed by the court."

Rule 70 "gives the district court a discrete and limited power to deal with parties who thwart final judgments by refusing to comply with orders to perform specific acts." *Analytical Eng'g, Inc. v. Baldwin Filters, Inc.*, 425 F.3d 443, 449 (7th Cir. 2005). Elem and Link contend that the district court erroneously converted a final money judgment at law into an injunction and that the judgment was enforceable only through a writ of execution.

This issue is no longer justiciable because the appeal of the order is now moot. Instead of posting a supersedeas bond, Link and his firm paid the full amount due to AirTran to avoid being held in contempt. Even if we agreed that the district court erred when it issued that order, we could not grant any meaningful relief because the defendants have already complied with it. *See Bradford Marine, Inc. v. M/V Sea Falcon*, 64 F.3d 585, 587 n.1 (11th Cir. 1995); *Fidelcor Mortg. Corp. v. Ins. Co. of N. Am.*, 820 F.2d 367, 370 (11th Cir. 1987) ("When it executed the satisfaction of the judgment, it included no reservation allowing it to proceed with an appeal on some issues; it satisfied the judgment in toto. Therefore, there is nothing left from which it may appeal."). No case or controversy about the merits of the Rule 70 order remains after the payment. *See RES-GA Cobblestone, LLC v. Blake Constr. & Dev., LLC*, 718 F.3d 1308, 1314 (11th Cir. 2013) ("Where no legally cognizable interest is at stake between the parties, a case becomes moot. This is so no matter how vehemently the parties continue to dispute the issues that animated the litigation." (internal quotation marks and citation omitted)).

We are befuddled by our dissenting colleague's contrary conclusion. (Dissenting Op. at 36–39). At oral argument, when we asked counsel for Elem, Link, and Link & Smith what injury they now suffered as a result of the Rule 70 order even though they had paid the

judgment, he answered, "Any injury now, perhaps not." We reiterate that because Link and Link & Smith have complied with the Rule 70 order by paying the judgment, we cannot afford them any meaningful relief even if that order was in error.

IV. CONCLUSION

We **AFFIRM** the summary judgment and award of attorney's fees and costs in favor of AirTran and **DISMISS** as moot the appeal of the order under Rule 70.

MARTIN, *Circuit Judge*, dissenting.

AirTran Airways, Inc. (AirTran) says that its suit seeks equitable relief, but it fails to make a critical showing for purposes of equity: that the defendants remain in possession of the disputed property. For the reasons that follow, I have come to understand that AirTran's suit seeks a legal remedy which is not permitted under the statute it relies on. Based on this understanding, I would reverse the District Court's grant of summary judgment in favor of AirTran, its order awarding attorney's fees and costs, and its later Rule 70 order enforcing the judgment.

I. THE DISTRICT COURT IMPROPERLY GRANTED SUMMARY JUDGMENT BY CLASSIFYING AIRTRAN'S CLAIMS AS EQUITABLE.

At issue is whether AirTran's suit against Brenda Elem, her attorney Mark Link, and his law firm Link & Smith, P.C. (Link & Smith) (collectively the defendants) to recover settlement funds subject to an equitable lien by agreement is permitted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a)(3)(B). This statute gives courts the power to grant "other appropriate equitable relief" only when enforcing a covered insurance plan. Specifically, a plan

fiduciary may bring a civil action under ERISA "to obtain other appropriate equitable relief . . to enforce the terms of the plan." 29 U.S.C. § 1132(a)(3)(B)(ii). The Supreme Court has construed this section to authorize only "those categories of relief that were typically available in equity." Mertens v. Hewitt Assocs., 508 U.S. 248, 256, 113 S. Ct. 2063, 2069 (1993). Thus, the statute offers no relief for legal claims. Whether a remedy is "legal or equitable depends on the basis for [the plaintiff's] claim and the nature of the underlying remedies sought." Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 213, 122 S. Ct. 708, 714 (2002) (alteration in original) (internal quotation marks omitted).

I certainly recognize that AirTran's claim here is one arising in equity. The clear terms of the insurance plan created an equitable lien by agreement over the money Ms. Elem got as a result of her third party suit from the moment she had actual or constructive possession of that money. However, on the facts before us, the only remedy available to AirTran is legal, not equitable, in nature. Money damages are traditionally a remedy at law, but can be equitable if the plaintiff seeks: (1) "specifically identifiable funds" in (2) the defendant's "possession and control." Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356, 362–63, 126 S. Ct. 1869, 1874 (2006) (internal quotation marks omitted). AirTran properly identified specific funds, but failed to establish that the identifiable funds are "in the possession and control" of the defendants. The remedy AirTran seeks is therefore a legal one and is not permitted under 29 U.S.C. § 1132(a)(3)(B).

A. A MONEY DAMAGE AWARD IS ONLY EQUITABLE IF THE DEFENDANT REMAINS IN POSSESSION.

Supreme Court precedent makes clear that a plaintiff proceeding in equity to recover funds from a defendant must, at a minimum, show that those funds are presently in the defendant's possession. In Walker v. Brown, 165 U.S. 654, 17 S. Ct. 453 (1897), the Supreme Court was asked to decide whether an equitable lien by agreement remained attached to certain Memphis city bonds in the hands of the widow of a businessman who pledged the bonds to plaintiff J. H. Walker & Co. (Walker). That businessman, Mr. Brown, had actually pledged the bonds to Walker for the benefit of a third party. As that third party got into financial difficulties, Mr. Brown paid its creditors the value of the bonds, retook possession of the bonds, and then gifted them to his wife before he passed away. The Supreme Court held that the lien by agreement was not extinguished when Mr. Brown bought them back, and that the "equitable lien will be enforced by a court of equity against the bonds in the hands of [Mrs.] Brown or against third persons who are volunteers or have notice." 165 U.S. at 664, 17 S. Ct. at 457 (emphasis added). The Supreme Court's discussion of available equitable relief turned on the current location and possession of the bonds. See also Ketchum v. St. Louis, 101 U.S. 306, 318 (1879) ("With that [equitable] lien the property itself was chargeable by whomsoever it or the funds accruing therefrom are or may be held.").

More recent cases also support the expectation that a defendant must still be in possession of the property subject to the lien to allow equitable recovery under 29 U.S.C. § 1132(a)(3)(B). The Supreme Court denied reimbursement in Knudson because the insurance company was not seeking to recover "particular funds or

property in the defendant's possession." 534 U.S. at 213, 122 S. Ct. at 714. The company sued Ms. Knudson, the beneficiary, instead of the trustee in charge of the Special Needs Trust where the money was held pursuant to California law. Because Ms. Knudson did not have the funds in her possession, the Court observed that the plaintiff's claim was "not that respondents hold particular funds that, in good conscience, belong to petitioners, but that petitioners are contractually entitled to some funds for benefits that they conferred." Id. at 214, 122 S. Ct. at 715. The Court held "where 'the property [sought to be recovered] or its proceeds have been dissipated so that no product remains, [the plaintiff's] claim is only that of a general creditor,' and the plaintiff 'cannot enforce a constructive trust of or an equitable lien upon other property of the [defendant].'" Id. at 213, 122 S. Ct. at 714 (alteration in original) (quoting Restatement of Restitution § 215, cmt. a, at 867); see also Restatement of Restitution § 215 cmt. b ("A person whose property is wrongfully taken by another is not entitled to priority over other creditors unless he proves that the wrongdoer not only once had the property or its proceeds, but still has the property or its proceeds or property in which the claimant's property or its proceeds have been mingled indistinguishably.").

In Sereboff, the Supreme Court noted that the "impediment to characterizing the relief in Knudson as equitable" was not present. Id. at 362, 126 S.Ct. at 1874. That is because, in contrast to Knudson, the plan administrator in Sereboff sought "particular funds or property in the defendant's possession," Knudson, 534 U.S. at 214, 122 S. Ct. at 708, where the identified fund was "preserved [in the Sereboffs'] investment accounts." Sereboff, 547 U.S. at 362–63, 126 S. Ct. at 1874 (alteration in original) (quoting Mid Atl. Med. Servs., LLC v.

Sereboff, 407 F.3d 212, 214 (4th Cir. 2005), aff'd sub nom. Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356, 126 S. Ct. 1869 (2006)).

This Court and other Circuit Courts have followed the Supreme Court's guidance that a defendant's current possession of the funds at issue is a necessary element of an equitable claim. See, e.g., Popowski v. Parrott, 461 F.3d 1367, 1373 (11th Cir. 2006) ("Unlike in Knudson, a significant portion of the funds specified went directly into the [insureds'] bank account and, thereby, was in their possession for purposes of this case. Thus, at the time they filed their suit, [the plan fiduciaries] sought 'not to impose personal liability on [the beneficiary], but to restore to the plaintiff[s] particular funds or property in [the beneficiary's] possession.'" (fourth alteration in original) (emphasis added) (quoting Knudson, 534 U.S. at 214, 122 S. Ct. at 714–15)); Treasurer, Trs. Of Drury Indus. Health Care Plan & Tr. v. Goding, 692 F.3d 888, 896 (8th Cir. 2012) ("In equity, there was no cause for restitution where the trustee of property wrongfully disposed of another's property, but no longer held that property or its product. A party who has been wrongfully divested of its property could only recover it if it proved not only that the other party once had property legally or equitably belonging to it, but also that he still holds the property or properties which is in whole or part its product." (citation omitted) (internal quotation marks and alterations omitted)); Bilyeu v. Morgan Stanley Long Term Disability Plan, 683 F.3d 1083, 1095 (9th Cir. 2012) (rejecting the argument that an equitable lien can be enforced against general assets when the specifically identified property has been dissipated); Loffredo v. Daimler AG, 500 F. App'x. 491, 499 (6th Cir. 2012) ("To plead claims for equitable relief the plaintiffs would have to allege either that the defendants currently (and

improperly) possess the assets dispersed from the trust or that they retain profits generated from that property."). In disagreeing with a case cited favorably by the majority, the Solicitor General of the United States also concluded that a plaintiff must establish the defendant's possession of the disputed funds to recover under this provision. See Brief for the United States as Amicus Curiae at 9, Thurber v. Aetna Life Ins. Co., et al., ___ U.S. ___, 134 S. Ct. 2723 (2014) (No. 13-130), 2014 WL 1783200 at *9 ("In the government's view, the court of appeals in this case erred in concluding that a plan fiduciary can enforce an equitable lien regardless of whether the funds at issue have been dissipated.").

B. AIRTRAN DID NOT ESTABLISH THAT DEFENDANTS HAVE POSSESSION OF THE SETTLEMENT FUNDS.

As soon as the settlement funds were transferred to the benefit of Ms. Elem, AirTran "could follow [those funds] into the hands" of the defendants. Panel Op. at 8 (quoting Barnes v. Alexander, 232 U.S. 117, 123, 34 S. Ct. 276, 278 (1914)). Once AirTran established who had the funds, its recovery against the person holding the funds would rightfully be classified as "equitable" according to Supreme Court and common law precedent. Yet what AirTran is entitled to do in equity, and what it actually did here, are very different things.

AirTran's complaint alleges "[u]pon information and belief, portion(s) of the funds to which the Plan is entitled are in the possession of Defendant Elem, Defendant Link and/or the Defendant Firm." AirTran's statement of material facts submitted in connection with its motion for summary judgment fails to offer any support for the allegation about possession made in its complaint. Though AirTran had ample opportunity in discovery to

inquire about the exact location of the distributed settlement money, it did not. Neither did AirTran ask the District Court for a restraining order or injunction to make sure that the funds were easy to identify once the case was resolved, as had happened in other reimbursement cases. See, e.g., Sereboff, 547 U.S. at 360, 126 S. Ct. at 1873 (noting that the Sereboffs agreed to preserve the disputed funds in an investment account until the suit was resolved); Popowski, 461 F.3d at 1370 ("[T]hey filed this suit along with a motion for a temporary restraining order and preliminary injunction to protect the settlement proceeds."). In its argument here, AirTran says that the "settlement funds could be followed into the hands of Elem, Link, and Link & Smith, P.C.," but it does not point to the money's current location. AirTran suggests that defendants engaged in "chicanery" by "concealing and then quickly 'spend[ing] all money received,'" but points to nothing in the record to support that proposition.

C. SEREBOFF'S LIMITATION ON "STRICT TRACING" DOES NOT IMPACT THIS CASE.

The majority forgives AirTran's failure to show defendants' possession of the settlement funds by stating that disbursal or commingling of the settlement funds is irrelevant to whether the claim is properly characterized as equitable. Ms. Elem, Mr. Link, and Link & Smith challenged the District Court's grant of summary judgment in part because AirTran did not establish that the funds it requested were still in the possession of any defendant. The majority says, mistakenly I believe, that the defendants' challenge is one "on the ground that AirTran failed to satisfy the strict tracing rules of equitable restitution." Panel Op. at 2. The majority then relies on Sereboff to reject this appeal. 547 U.S. at 364, 126 S. Ct. at 1875 (discussing the "strict tracing rules"

that applied to equitable restitution at common law). But I do not read Sereboff in the same way as the majority.

In Sereboff, the beneficiaries of an ERISA-covered health insurance plan received payment from the plan to cover medical expenses resulting from a car accident. The Sereboffs later settled a lawsuit they had filed regarding the car accident, and the terms of the plan called for the money paid in settlement to go to reimburse the administrator. The Sereboffs argued that recovery of settlement funds paid by a third party—and not directly from the plan—was not "equitable relief" under 29 U.S.C. § 1132(a)(3)(B) because "[t]he money in [the beneficiaries'] investment account cannot be traced to [the plan administrator]." Respondent Reply Brief at 9, Sereboff, 547 U.S. 356, 126 S. Ct. 1869 (No. 05-260), 2006 WL 717048 at *9. The Supreme Court rejected the Sereboffs' argument because "no tracing requirement of the sort asserted by the Sereboffs applies to equitable liens by agreement or assignment." Sereboff, 547 U.S. at 365, 126 S. Ct. at 1875. In support of its position, the Court turned to "case law from the days of the divided bench"—meaning cases heard during the period when the United States had two parallel courts, one of equity and one of law—which did not require the holder of an equitable lien by agreement to trace the res directly from the defendant back to the plaintiff. Id. at 363–64, 126 S. Ct. at 1874–75 (discussing Barnes, 232 U.S. at 199–23, 34 S. Ct. at 277–78).

In its discussion of strict tracing, the Supreme Court made a distinction between equitable liens sought as a matter of restitution and equitable liens by agreement. For equitable liens sought as a matter of restitution, strict tracing is required, but for equitable liens by agreement, it is not. Sereboff, 547 U.S. at 364–65, 126

S. Ct. at 1875–76. Further, the Court cabined its discussion of strict tracing to the type of tracing requirement "asserted by the Sereboffs." Id. at 365, 126 S. Ct. at 1875. As described above, the Sereboffs argued that equitable tracing required the plaintiff to trace the defendant's funds back to the plaintiff himself, and not to a third party. The Supreme Court rejected this argument, and held that equitable relief was still available where the plaintiff could not "identify an asset they originally possessed, which was improperly acquired and converted into property the defendant held." Id. (emphasis added). Later, this Court interpreted Sereboff's tracing language to eliminate only the requirement that disputed funds originate with the plaintiff. See Admin. Comm. for Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Horton, 513 F.3d 1223, 1227 n.3 (11th Cir. 2008) ("[T]he Sereboff Court explained that strict tracing rules need not apply for an equitable lien to properly attach to the settlement funds; that is, although the disputed funds had never actually been in the possession of the plan, the plan could seek to 'recover' property that belonged to it in good conscience under the plan agreement." (emphasis added)).

The majority relies on what I believe is a misapplication of Sereboff, accepted by some of our sister circuits, to characterize the recovery of assets no longer in the defendant's possession as equitable relief. See, e.g., Cusson v. Liberty Life Assurance Co. of Boston, 592 F.3d 215, 231 (1st Cir. 2010) (determining that an insurer need not identify a "specific account in which the funds are kept or prove[] that they are still in [the defendant's] possession"). I do not accept this interpretation because the defendants in Sereboff were

still in possession of the funds—the Sereboff parties had stipulated that the funds were securely set aside in an investment account. See Sereboff, 547 U.S. at 360, 126 S.Ct. at 1873. So in Sereboff the Supreme Court was never asked to decide whether a defendant's possession at the time of the suit was necessary for an action in equity.

D. EQUITABLE RELIEF IS NOT AVAILABLE AGAINST DEFENDANTS WHO DO NOT HAVE POSSESSION OF THE DISPUTED PROPERTY.

If the settlement had instead been issued to Ms. Elem in the form of a luxury automobile, AirTran could exercise its equitable lien only by locating the automobile or the proceeds of the sale of the automobile and suing the person who had possession. It would make no sense to sue in equity to recover a car from someone who does not have it. And, the result is the same when a plaintiff brings a claim for "other equitable relief" without establishing who is in possession. At core, a plaintiff's ability to seek equitable relief over a res cannot be separated from the ongoing existence and location of that res or its proceeds. More to the point, we, as a court sitting in equity, cannot reverse engineer what happened to the plaintiff's property by assuming that one or more of the named defendants now has it. Yet, that is what the majority does here.

The District Court's grant of summary judgment entitled AirTran to recover the $131,704.28 it paid for Ms. Elem's medical expenses. The District Court later clarified that its "[j]udgment requires reimbursement of AirTran by all Defendants because all three possess settlement funds that belong 'in good conscience' to the Plan.'" The majority opinion repeats this idea that the

funds AirTran seeks to recover are "in 'the possession and control' of Elem and Link." Panel Op. at 8. But nothing in the record supports either conclusion. To the contrary, only Ms. Elem and Link & Smith received distributions from the settlement amount, and AirTran made no assertions about whether the money remained in their possession when it filed its motion for summary judgment. The record before us simply tells us nothing about where the money is. It could be disbursed, it could be commingled, or it could be tucked under Ms. Elem's mattress. By the District Court's order, Mr. Link is liable in equity for a res that he does not possess. Whatever retribution is appropriate for Mr. Link's "sin[s]," Panel Op. at 2, it cannot lie in equity. If Ms. Elem and Link & Smith no longer have the funds, they continue to be subject to legal claims, but the equitable claim has dissipated. AirTran's claims simply fall outside the relief permitted by 29 U.S.C. § 1132(a)(3)(B).

II. THE DISTRICT COURT IMPROPERLY GRANTED ATTORNEY'S FEES AND COSTS.

The defendants also challenge the District Court's grant of attorney's fees and costs. Under 29 U.S.C. § 1132(g), attorney's fees may be awarded at the Court's discretion to a party who achieves "some success on the merits." Hardt v. Reliance Standard Life Ins. Co., 560 U.S. 242, 255, 130 S. Ct. 2149, 2158 (2010). Because I view summary judgment as having been improperly granted in favor of AirTran, the District Court's related award of attorney's fees and costs should also be vacated. See Ogden v. Blue Bell Creameries U.S.A., Inc., 348 F.3d 1284, 1288 (11th Cir. 2003) (vacating award of attorney's fees after holding that the District Court improperly awarded equitable relief under ERISA).

III. DEFENDANTS' APPEAL OF THE DISTRICT COURT'S RULE 70 ORDER IS NOT MOOT AND THE RULE 70 ORDER WAS GRANTED TO ENFORCE AN INCORRECT JUDGMENT.

Finally, I turn to the defendants' appeal of the District Court's Rule 70 order enforcing judgment. The majority opinion dismisses the appeal as moot because defendants paid the required amount to AirTran, eliminating any "case or controversy about the merits of the Rule 70 order." Panel Op. at 21. I disagree with this holding on both factual and legal bases.

The defendants' payment to AirTran was conditioned in part on the outcome of the Rule 70 order appeal. The majority opinion highlights a purported stipulation by both parties at oral argument that the payments were subject to "the disposition of the appeal of the summary judgment and the award of attorney's fees and costs." Id. at 6. I heard no such stipulation at oral argument. AirTran's counsel admitted that the payment "was subjectively conditioned on repayment if there was a final ruling in favor of [defendants]," Oral Arg. Recording at 13:36 (Feb. 28, 2014), while counsel for defendants stated that the money was "turned over to other side to hold in trust" and that if "we win, we get it [back]," id. at 00:52, 01:09. At no point did the parties mention that conditional repayment was tied only to the appeal challenging summary judgment and award of attorney's fees and costs. This matters because defendants had two separate appeals before us: one challenging the summary judgment grant and award of attorney's fees and costs, Case No. 13-11738-BB, and the other challenging the Rule 70 order, Case No. 13-14912-BB. Everything I see indicates to me that defendants' payment was conditioned on the outcome of both appeals. For example, in their response to AirTran's motion for contempt, Mr. Link and

Link & Smith state that they "are paying the amounts claimed under protest and threat of civil and/or criminal contempt while the appeal of both Orders are pending in the 11th Circuit." Without explicit documentation or statements to the contrary, I see no basis for putting limitations on the defendants' conditional payment in our evaluation of mootness.

I do not read our prior case law to comport with the majority's analysis. While "payment of a judgment and an acknowledgement of satisfaction will moot an appeal from the judgment," RES-GA Cobblestone, LLC v. Blake Const. and Dev., LLC (Cobblestone), 718 F.3d 1308, 1315 (11th Cir. 2013), it is also true that "what matters is whether the parties' actions objectively manifest an intent to abandon the issues on appeal." Id. at 1315. In Cobblestone, we observed that the appellant "never purported to reserve the right to continue to pursue [the] appeal," did not intend to "claw back the costs and fees he paid," and signed a consent agreement settling the suit to determine that the appeal was mooted. Id. at 1315–16; see also Fidelcor Mortg. Corp. v. Ins. Co. of N. Am., 820 F.2d 367, 370 (11th Cir. 1987) (mooting appeal where appellant made "no reservation allowing [him] to proceed with an appeal"); cf. Alvarez-Perez v. Sanford-Orlando Kennel Club, Inc., 518 F.3d 1302, 1305–08 (11th Cir. 2008) (declining to dismiss an appeal as moot where the parties "acted in all respects as though the appeal and cross-appeal were alive and that they were awaiting a decision" and "continued to litigate the case in this Court as though nothing had changed"); Ass'n for Disabled Ams., Inc. v. Integra Resort Mgmt., Inc., 387 F.3d 1241, 1243 (11th Cir. 2004) (holding that an appeal was not moot where appellants "specifically reserved their right to appeal" and there was no "evidence of some intent to end the litigation"). Like the appellants in Alvarez-Perez, here

the defendants' "actions speak loudly enough to drown out" any indication that they regarded the conditional payment to terminate either of their appeals. 518 F.3d at 1307. Both parties briefed the Rule 70 order appeal after the payment was made to AirTran, and neither brief claimed mootness. The majority offers no evidence that the parties "objectively manifest[ed] an intent to abandon the issues" as is necessary by this Court's precedent.

The defendants' counsel made a statement at oral argument, only part of which is quoted by the majority to oppose the position I have taken here. See Panel Op. at 21. Though the attorney for Ms. Elem, Mr. Link and his law firm did say there was "perhaps not" a current injury resulting from that order, he went on to explain "but it could cause injury in the future such as having to come back up here again and fight that issue." Oral Arg. Recording at 02:58–03:06 (Feb. 28, 2014). Even accepting that counsel did not fully explain his clients' ongoing injury at that moment in the oral argument, the fact remains that, much like a supersedeas bond, defendants have an ongoing injury in the form of their conditional payment suspended in escrow.

The Rule 70 order appeal is not mooted by defendants' conditional payment made under threat of contempt. The District Court's grant of summary judgment improperly awarded non-equitable relief to AirTran in violation of 29 U.S.C. § 1132(a)(3)(B), thus an order enforcing that judgment cannot stand. Both the grant of summary judgment and the Rule 70 order should be vacated.

For these reasons I respectfully dissent.

APPENDIX D

UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

Nos. 13-11738 & 13-14912

AIRTRAN AIRWAYS, INC.,

Plaintiff-Appellee,

v.

BRENDA ELEM, MARK D. LINK, and LINK & SMITH, P.C.,

Defendants-Appellants.

On Appeal from the United States District Court
for the Northern District of Georgia
D.C. Civil Action No. 1:10-cv-03673-ODE

Before: WILLIAM PRYOR and MARCUS, *Circuit Judges*, and HONEYWELL,* *District Judge*.

Filed: December 2, 2014

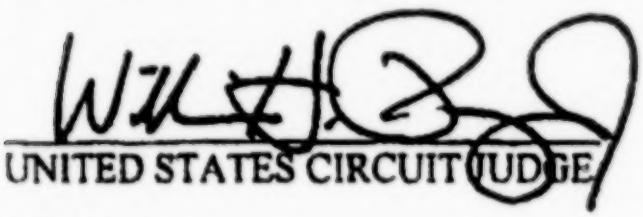
* Honorable Charlene Edwards Honeywell, United States District Judge for the Middle District of Florida, sitting by designation.

ON PETITION(S) FOR REHEARING AND
PETITION(S) FOR REHEARING EN BANC

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:



UNITED STATES CIRCUIT JUDGE

ORD-42

No. 14-723

In the Supreme Court of the United States

ROBERT MONTANILE,

Petitioner,

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

JOINT APPENDIX

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Attorney for Respondent

July 6, 2015

Petition for Writ of Certiorari filed December 16, 2014
Petition for Writ of Certiorari granted March 30, 2015

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Declaration of Brian S. King (ECF No. 35-2) (August 27, 2013) JA 34

Plaintiff's Motion for Summary Judgment and Memorandum of Law in Support of its Motion for Summary Judgment Excerpt (ECF No. 36) (August 27, 2013) JA 37

Affidavit In Support of Plaintiff's Motion for Summary Judgment (ECF No. 36-1) (August 27, 2013) JA 41

Summary Plan Description Excerpt (ECF No. 36-4) August 27, 2013) JA 45

Reimbursement Agreement/Workers Compensation Claims Only (ECF No. 36-5) (August 27, 2013) JA 50

Plaintiff's Memorandum of Law in Opposition to Defendant's Motion for Summary Judgment Excerpt (ECF No. 38) (September 13, 2013) JA 53

Defendant Robert Montanile's Memorandum in Opposition to Plaintiff's Motion for Summary Judgment (ECF No. 39) (September 25, 2013) JA 55

Second Declaration of Brian S. King (ECF No. 39-2) (September 25, 2013) JA 66

Declaration of Robert Montanile (ECF No. 39-3) (September 25, 2013) JA 75

Defendant Robert Montanile's Reply Memorandum in Support of his Motion for Summary Judgment (ECF No. 40) (October 9, 2013) JA 81

Plaintiff's Reply to Robert Montanile's Memorandum in Opposition to Plaintiff's Motion for Summary Judgment Excerpt (ECF No. 41) (October 9, 2013) JA 90

The following opinions, decisions, judgments, and orders have been omitted in printing this joint appendix because they appear on the following pages in the appendix to the Petition for a Writ of Certiorari:

Appendix A Opinion of the United States Court of Appeals for the Eleventh Circuit (November 25, 2014) App. 1

Appendix B Order on Cross-Motions for Summary Judgment (March 17, 2014) App. 19

Appendix C Opinion of the United States Court of Appeals for the Eleventh Circuit (*AirTran*) (September 23, 2014) App. 46

Appendix D On Petition(s) for Rehearing And Petition(s) for Rehearing En Banc (*AirTran*)
(December 2, 2014) App. 77

RELEVANT DOCKET ENTRIES

United States District Court for the Southern District of Florida (West Palm Beach)

9:12-cv-80746-DLB

Board of Trustees of the National Elevator Industry Health Benefit Plan v. Montanile

Date Filed	#	Docket Text
07/11/2012	1	COMPLAINT against Board of Trustees of the National Elevator Industry Health Benefit Plan. Filing fee $ 350.00 receipt number 113C-4884807, filed by Board of Trustees of the National Elevator Industry Health Benefit Plan. (Attachments: # 1 Exhibit A, # 2 Civil Cover Sheet, # 3 Summon(s))(Kolb, John) (Entered: 07/11/2012) (Entered: 07/11/2012)
07/11/2012	2	Judge Assignment to Judge Donald M. Middlebrooks (vjk) (Entered: 07/11/2012)
07/11/2012	3	Summons Issued as to Robert Montanile. (vjk) (Entered: 07/11/2012)
07/25/2012	4	ORDER REFERRING CASE and Setting Trial Date; referring to Magistrate Judge Dave Lee Brannon for Pretrial Proceedings, (Calendar Call set for 3/6/2013 01:15 PM before Judge Donald M. Middlebrooks., Jury Trial set for

		3/11/2013 09:00 AM before Judge Donald M. Middlebrooks., Status Conference set for 3/6/2013 01:15 PM before Judge Donald M. Middlebrooks.) Signed by Judge Donald M. Middlebrooks on 7/25/12. (mg) (Entered: 07/25/2012)
08/01/2012	5	ORDER SETTING TELEPHONIC SCHEDULING CONFERENCE, (Telephone Conference set for 8/16/2012 at 11:00 AM in West Palm Beach Division before Magistrate Judge Dave Lee Brannon.) Signed by Magistrate Judge Dave Lee Brannon on 8/1/2012. (sa) (Entered: 08/01/2012)
08/16/2012	6	Minute Entry for proceedings held before Magistrate Judge Dave Lee Brannon: Telephone Conference held on 8/16/2012. (Digital 11:06:30.) (sa) (Entered: 08/16/2012)
08/16/2012	7	PRETRIAL SCHEDULING ORDER: Amended Pleadings due by 9/10/2012. Discovery due by 12/3/2012. Joinder of Parties due by 9/10/2012. Motions due by 12/17/2012. Pretrial Stipulation due by 2/11/2013. Signed by Magistrate Judge Dave Lee Brannon on 8/16/2012. (sa) (Entered: 08/16/2012)

08/16/2012	8	ORDER REFERRING CASE to Mediation. Signed by Magistrate Judge Dave Lee Brannon on 8/16/2012. (sa) (Entered: 08/16/2012)
09/06/2012	9	MOTION for Extension of Time to File Answer RE: Complaints re 1 Complaint, *to 9/18/2012* by Robert Montanile. (Tucker, John) (Entered: 09/06/2012)
09/14/2012	10	ORDER granting 9 Stipulated Motion for Extension of Time to Answer RE: Complaints re 1 Complaint, Robert Montanile answer due 9/18/2012. Signed by Judge Donald M. Middlebrooks on 9/14/2012. (ls) (Entered: 09/14/2012)
09/17/2012	11	ANSWER and Affirmative Defenses to Complaint by Robert Montanile.(Tucker, John) (Entered: 09/17/2012)
10/09/2012	12	MOTION to Appear Pro Hac Vice, Consent to Designation, and Request to Electronically Receive Notices of Electronic Filing for Brian S. King. Filing Fee $ 75.00. Receipt # 46503. (ksa) (Entered: 10/11/2012)
10/11/2012	13	ORDER denying 12 Motion to Appear Pro Hac Vice, Consent to Designation, and Request to Electronically Receive Notices of Electronic Filing of Attorney Brian S. King Notice of

		Termination delivered by US Mail to Brian King. Signed by Judge Donald M. Middlebrooks on 10/11/2012. (ls) (Entered: 10/11/2012)
12/18/2012		Attorney Brian S. King representing Montanile, Robert (Defendant) Activated. (cw) (Entered: 12/18/2012)
12/18/2012	14	MOTION to Appear Pro Hac Vice, Consent to Designation, and Request to Electronically Receive Notices of Electronic Filing for Brian S. King. Filing Fee $ 75.00. Receipt # 46530. (ksa) (Entered: 12/18/2012)
12/19/2012	15	ORDER denying 14 Motion to Appear Pro Hac Vice, Consent to Designation, and Request to Electronically Receive Notices of Electronic Filing of Attorney Brian S. King Notice of Termination delivered by US Mail to Brian King. Signed by Judge Donald M. Middlebrooks on 12/19/2012. (ls) (Entered: 12/19/2012)
12/28/2012	16	NOTICE of Compliance re: Certification of Brian S. King by Robert Montanile re 15 Order on Motion to Appear Pro Hac Vice, (yha) (Entered: 12/31/2012)
01/03/2013	17	NOTICE by Robert Montanile *to Receive Electronic Notification for Brian S. King* (Tucker, John)

		(Entered: 01/03/2013)
01/23/2013	18	MOTION to Appear Pro Hac Vice, Consent to Designation, and Request to Electronically Receive Notices of Electronic Filing for Brian S. King. (ksa) (Entered: 01/25/2013)
01/30/2013	19	ORDER granting 18 Motion to Appear Pro Hac Vice, Consent to Designation, and Request to Electronically Receive Notices of Electronic Filing. Signed by Judge Donald M. Middlebrooks on 1/30/2013. (ls) (Entered: 01/30/2013)
02/01/2013	20	*ORDER REQUIRING STATUS REPORT Signed by Judge Donald M. Middlebrooks on 2/1/2013. (sw) (Entered: 02/01/2013)
02/05/2013	21	ORDER Requiring Status Report, (Status Report due by 5PM on 2/5/2013.) Signed by Judge Donald M. Middlebrooks on 2/4/2013. (ls) (Entered: 02/05/2013)
02/05/2013	22	STATUS REPORT by Board of Trustees of the National Elevator Industry Health Benefit Plan (Kolb, John) (Entered: 02/05/2013)
02/07/2013	23	ORDER re 22 Status Report filed by Board of Trustees of the National Elevator Industry Health Benefit Plan. Signed by Judge Donald M. Middlebrooks on 2/6/2013. (ls) (Entered:

		02/07/2013)
02/08/2013	24	CONSENT to Jurisdiction by US Magistrate Judge by Board of Trustees of the National Elevator Industry Health Benefit Plan, Robert Montanile (Kolb, John) (Entered: 02/08/2013)
02/11/2013	25	ORDER REFERRING CASE to Magistrate Judge Dave Lee Brannon for Trial. Judge Donald M. Middlebrooks no longer assigned as presider/referral judge(s) in case. Signed by Judge Donald M. Middlebrooks on 2/11/2013. (ls) (Entered: 02/12/2013)
02/12/2013	26	ORDER SETTING TELEPHONIC STATUS CONFERENCE, (Telephonic Status Conference set for 2/15/2013 at 1:00 PM in West Palm Beach Division before Magistrate Judge Dave Lee Brannon.) Signed by Magistrate Judge Dave Lee Brannon on 2/12/2013. (sa) (Entered: 02/12/2013)
02/15/2013	27	Minute Entry for proceedings held before Magistrate Judge Dave Lee Brannon: Status Conference held on 2/15/2013. (Digital 14:00:14.) (sa) (Entered: 02/15/2013)
02/20/2013	28	MOTION for Entry of Briefing Schedule by Robert Montanile.

		(Tucker, John) Modified Text on 2/21/2013 (ls). (Entered: 02/20/2013)
02/21/2013	29	ORDER SETTING TRIAL BEFEORE MAGISTRATE JUDGE AND AMENDED PRETRIAL SCHEDULING ORDER. Granting in Part and Denying In Part 28 MOTION for Entry of Briefing Schedule. (1-Day Bench Trial set for 8/13/2013 at 9:30 AM in West Palm Beach Division before Magistrate Judge Dave Lee Brannon., Status Conference set for 8/7/2013 at 1:30 PM in West Palm Beach Division before Magistrate Judge Dave Lee Brannon.), Motion terminated: 28 MOTION for Entry of Briefing Schedule filed by Robert Montanile. Signed by Magistrate Judge Dave Lee Brannon on 2/21/2013. (sa) (Entered: 02/21/2013)
02/22/2013		Set/Reset Scheduling Order Deadlines pursuant to DE# 29: Mediation Deadline 6/14/2013. Dispositive Motions due by 4/15/2013. Pretrial Stipulation due by 7/15/2013. (dgj) (Entered: 02/22/2013)
03/25/2013	30	ORDER SCHEDULING SETTLEMENT CONFERENCE: Settlement Conference set for

		6/6/2013 at 10:00 AM in West Palm Beach Division before Magistrate Judge William Matthewman. Signed by Magistrate Judge William Matthewman on 3/25/2013. (kza) (Entered: 03/25/2013)
06/06/2013	31	Minute Entry for proceedings held before Magistrate Judge William Matthewman: Settlement Conference held on 6/6/2013. Case did not settle. (Digital 10:06:04--10:16:14.) (nbt) (Entered: 06/06/2013)
07/09/2013	32	MOTION to Strike *Trial Date* by Robert Montanile. Responses due by 7/26/2013 (Tucker, John). Added MOTION for Entry of Briefing Schedule on 7/10/2013 (ls). (Entered: 07/09/2013)
07/10/2013	33	Clerks Notice to Filer re 32 MOTION to Strike *Trial Date and for Entry of Briefing Schedule*. **Motion with Multiple Reliefs Filed as One Relief**; ERROR - The Filer selected only one relief event and failed to select the additional corresponding events for each relief requested in the motion. The docket entry was corrected by the Clerk. It is not necessary to refile this document but future filings must comply with the instructions in the CM/ECF Attorney User's Manual.

		(ls) (Entered: 07/10/2013)
07/22/2013	34	ORDER Granting 32 MOTION to Strike *Trial Date* MOTION for Entry of Briefing Schedule filed by Robert Montanile and removing Trial from calendar and Establishing Summary Judgment Briefing Schedule. (Motion for Summary Judgment due by 8/27/2013., Responses due by 9/24/2013, Replies due by 10/9/2013.) Signed by Magistrate Judge Dave Lee Brannon on 7/22/2013. (sa) (Entered: 07/22/2013)
08/27/2013	35	MOTION for Summary Judgment by Robert Montanile. Responses due by 9/13/2013 (Attachments: # 1 Affidavit Notice of Filing Declaration, # 2 Affidavit Declaration of Brian S. King, # 3 Exhibit Exhibit A(1), # 4 Exhibit Exhibit A(2), # 5 Exhibit Exhibit B(1), # 6 Exhibit Exhibit B(2), # 7 Exhibit Exhibit B(3), # 8 Exhibit Exhibit C(1), # 9 Exhibit Exhibit C(2))(Tucker, John) (Entered: 08/27/2013)
08/27/2013	36	MOTION for Summary Judgment by Board of Trustees of the National Elevator Industry Health Benefit Plan. Responses due by 9/13/2013 (Attachments: # 1 Affidavit of John McGowan, # 2 Affidavit Exhibit A, # 3 Affidavit

		Exhibit B-1, # 4 Affidavit Exhibit B-2, # 5 Affidavit Exhibit C)(Kolb, John) (Entered: 08/27/2013)
08/28/2013	37	Clerks Notice to Filer re 35 MOTION for Summary Judgment. Docket Text Does Not Match Document; ERROR - The Filer failed to enter a title in the docket text that matches the title of the document. It is not necessary to refile the document. (ls) (Entered: 08/28/2013)
09/13/2013	38	RESPONSE in Opposition re 35 MOTION for Summary Judgment filed by Board of Trustees of the National Elevator Industry Health Benefit Plan. (Kolb, John) (Entered: 09/13/2013)
09/25/2013	39	RESPONSE in Opposition re 36 MOTION for Summary Judgment filed by Robert Montanile. (Attachments: # 1 Certification Certificate of Service, # 2 Affidavit Declaration, # 3 Affidavit Declaration)(Tucker, John) (Entered: 09/25/2013)
10/09/2013	40	MEMORANDUM in Support re 35 MOTION for Summary Judgment by Robert Montanile. (Tucker, John) (Entered: 10/09/2013)
10/09/2013	41	REPLY to Response to Motion re 36 MOTION for Summary Judgment filed by Board of Trustees of the National Elevator

		Industry Health Benefit Plan. (Attachments: # 1 Affidavit Supplement Affidavit of John McGowan, # 2 Affidavit Exhibit A to Supplemental Affidavit of John McGowan) (Kolb, John) (Entered: 10/09/2013)
10/09/2013	42	REPLY to Response to Motion re 35 MOTION for Summary Judgment filed by Robert Montanile. (ls) (See Image at DE # 40) (Entered: 10/10/2013)
10/10/2013	43	Clerks Notice to Filer re 40 Memorandum. **Wrong Event Selected**; ERROR - The Filer selected the wrong event. The document was re-docketed by the Clerk, see [de#42]. It is not necessary to refile this document. (ls) (Entered: 10/10/2013)
11/20/2013	44	Notice of Supplemental Authority re 35 MOTION for Summary Judgment by Robert Montanile (Tucker, John) (Entered: 11/20/2013)
03/17/2014	45	ORDER ON CROSS-MOTIONS FOR SUMMARY JUDGMENT. Denying 35 Defendant's Motion for Summary Judgment; Granting 36 Plaintiff's Motion for Summary Judgment. Signed by Magistrate Judge Dave Lee Brannon on 3/17/2014. (sa) (Entered: 03/18/2014)

03/17/2014	46	FINAL JUDGMENT in favor of Board of Trustees of the National Elevator Industry Health Benefit Plan against Robert Montanile. Clerk shall close case and deny all pending motions as moot. Signed by Magistrate Judge Dave Lee Brannon on 3/17/2014. (sa) (Entered: 03/18/2014)
04/16/2014	47	NOTICE by Robert Montanile *Notice of Appeal* (Tucker, John) (Entered: 04/16/2014)
04/16/2014	48	Notice of Appeal (See de# 47 for image) by Robert Montanile as to 46 Judgment, 45 Order on Motion for Summary Judgment. Filing fee $(NOT PAID). Within fourteen days of the filing date of a Notice of Appeal, the appellant must complete the Eleventh Circuit Transcript Order Form regardless of whether transcripts are being ordered [Pursuant to FRAP 10(b)]. For information go to our FLSD website under Transcript Information. (mc) (Entered: 04/17/2014)
04/17/2014	49	Clerks Notice to Filer re 47 Notice (Other). **Wrong Event Selected**; ERROR - The Filer selected the wrong event. The document was re-docketed by the Clerk, see de# 48. It is not necessary to refile this document. (mc) (Entered: 04/17/2014)

04/17/2014		Transmission of Notice of Appeal, Order, Final Judgment and Docket Sheet to US Court of Appeals re 48 Notice of Appeal. Notice has been electronically mailed. (mc) (Entered: 04/17/2014)
04/22/2014	50	Acknowledgment of Receipt of NOA from USCA re 48 Notice of Appeal, filed by Robert Montanile. Date received by USCA: 4/17/2014. USCA Case Number: 14-11678-C. (mc) (Entered: 04/22/2014)
04/30/2014	51	TRANSCRIPT INFORMATION FORM by Robert Montanile re 48 Notice of Appeal,. No Transcript Requested. (Tucker, John) (Entered: 04/30/2014)
05/02/2014	52	USCA Appeal Fees received on 5/2/2014 in the amount of $505.00 receipt number FLS00003013 re 48 Notice of Appeal, filed by Robert Montanile (mc) (Entered: 05/02/2014)
07/01/2014	53	Pursuant to F.R.A.P. 11(c), the Clerk of the District Court for the Southern District of Florida certifies that the record is complete for purposes of this appeal re: 48 Notice of Appeal, Appeal No. 14-11678-CC. The entire record on appeal is available electronically. (mc) (Entered: 07/01/2014)

01/02/2015	54	MANDATE of USCA (certified copy) AFFIRM Judgment/ Order of the district court with courts opinion re 48 Notice of Appeal, filed by Robert Montanile; Date Issued: 1/2/2015; USCA Case Number: 14-11678-CC (amb) (Entered: 01/05/2015)
04/03/2015	55	WRIT OF CERTIORARI DENIED [sic] by US Supreme Court. The court's mandate having previously issued, no further action will be taken by this court; re 48 Notice of Appeal, filed by Robert Montanile. USCA# 14-11678-CC (mc) (Entered: 04/03/2015)

United States Court of Appeals
for the Eleventh Circuit

14-11678

Board of Trustees Natl. Elev. v.
Robert Montanile

04/17/2014 CIVIL APPEAL DOCKETED. Notice of appeal filed by Appellant Robert Montanile on 04/16/2014. Fee Status: Fee Not Paid.

04/30/2014 APPEARANCE of Counsel Form filed by Victor O'Connell for Appellant (ECF: Victor O'Connell)

04/30/2014 Added Attorney(s) Victor O'Connell for party(s) Appellant Robert Montanile, in case 14-11678.

04/30/2014 TRANSCRIPT INFORMATION FORM SUBMITTED by Attorney Victor O'Connell for Appellant Robert Montanile. No hearings. (ECF: Victor O'Connell)

05/01/2014 TRANSCRIPT INFORMATION form filed by Attorney Victor O'Connell for Appellant Robert Montanile. No hearings.

05/02/2014 Appellate fee was paid on 05/02/2014 as to Appellant Robert Montanile.

05/06/2014 APPEARANCE of Counsel Form filed by Peter K. Stris for Appellant (ECF: Peter Stris)

05/06/2014 Civil Appeal Statement filed by Attorney

Victor O'Connell for Appellant Robert Montanile. (ECF: Victor O'Connell)

05/06/2014 Appellant's Certificate of Interested Persons and Corporate Disclosure Statement filed by Appellant Robert Montanile. (ECF: Victor O'Connell)

05/08/2014 Briefing Notice issued to Appellant Robert Montanile. The appellants brief is due on or before 05/27/2014. The appendix is due on or before 06/03/2014.

05/08/2014 Added Attorney(s) Peter K. Stris for party(s) Appellant Robert Montanile, in case 14-11678.

05/27/2014 Appellant's brief filed by Robert Montanile. (ECF: Peter Stris)

05/28/2014 Received paper copies of EBrief filed by Appellant Robert Montanile.

05/29/2014 Appendix filed [2 VOLUMES] by Appellant Robert Montanile. (ECF: Peter Stris)

06/02/2014 Received paper copies of EAppendix filed by Appellant Robert Montanile. 2 VOLUMES 2 SETS

06/30/2014 APPEARANCE of Counsel Form filed by John David Kolb for Board of Trustees of the National Elevator Industry Health Benefit Plan. (ECF: John Kolb)

06/30/2014 Appellee's Brief filed by Appellee Board of

Trustees of the National Elevator Industry Health Benefit Plan. (ECF: John Kolb)

06/30/2014 E-filed Appearance of Counsel processed for Attorney John David Kolb for Appellee Board of Trustees of the National Elevator Industry Health Benefit Plan in 14-11678.

06/30/2014 Corrected brief received on 07/02/2014 from Appellee Board of Trustees of the National Elevator Industry Health Benefit Plan. 7 copies received. All deficiencies have been corrected.

07/01/2014 Notice of deficient Appellee brief filed by Attorney John David Kolb for Appellee Board of Trustees of the National Elevator Industry Health Benefit Plan. Deficiencies: missing oral argument statement.

07/01/2014 Received paper copies of EBrief filed by Appellee Board of Trustees of the National Elevator Industry Health Benefit Plan.

07/01/2014 Corrected Appellee's Brief filed by Appellee Board of Trustees of the National Elevator Industry Health Benefit Plan. (ECF: John Kolb)

07/17/2014 Reply Brief filed by Appellant Robert Montanile. (ECF: Peter Stris)

07/21/2014 Received paper copies of EBrief filed by Appellant Robert Montanile.

07/25/2014 The Court has determined that oral argument will be necessary in this case. Please forward 3 additional copies of the 2 volumes of Appendix filed 5/29/14 by Attorney Peter K. Stris for Appellant Robert Montanile to the Clerk's Office, Attention: Jenifer Tubbs. Your prompt attention to this matter is appreciated.

07/29/2014 Additional copies of Appendix received from Peter K. Stris for Robert Montanile and forwarded to the record room.

08/11/2014 Assigned to tentative calendar number 5 in Montgomery during the week of November 17, 2014.

09/11/2014 Certificate of Interested Persons and Corporate Disclosure Statement filed by Attorney John David Kolb for Appellee Board of Trustees of the National Elevator Industry Health Benefit Plan. On the same day the CIP is served, the party filing it must also complete the court's web-based stock ticker symbol certificate at the link here http://www.ca11.uscourts.gov/web-based-cip or on the court's website. See 11th Cir. R. 26.1-2(b). (ECF: John Kolb)

09/23/2014 Calendar issued as to cases to be orally argued the week of 11/17/2014 in Montgomery, Alabama. Counsel are

directed to electronically acknowledge receipt of this calendar by docketing the Calendar Receipt Acknowledged event in ECF. Counsel must be logged into CM/ECF in order to view the attached calendar.

09/23/2014 Oral argument scheduled. Argument Date: Friday, 11/21/2014 Argument Location: Montgomery, AL.

09/25/2014 Public Communication: E-mail to Appellant and Appellee from the court.

09/26/2014 Attorney Peter K. Stris for Appellant Robert Montanile hereby acknowledges receipt of a copy of the printed calendar for 11/17/2014. Peter K. Stris, Tel: (424) 212-7090, will present argument. (ECF: Peter Stris)

09/29/2014 Attorney John David Kolb for Appellee Board of Trustees of the National Elevator Industry Health Benefit Plan hereby acknowledges receipt of a copy of the printed calendar for 11/21/2014. John D. Kolb, 502.214.6125 will present argument. (ECF: John Kolb)

10/06/2014 Supplemental Appellant's Letter Brief filed by Appellant Robert Montanile. (ECF: Peter Stris)

10/14/2014 Supplemental Appellee's Letter Brief filed by Appellee Board of Trustees of the National Elevator Industry Health

	Benefit Plan. (ECF: John Kolb)
11/21/2014	Oral argument held. Oral Argument participants were Peter K. Stris for Appellant Robert Montanile and John David Kolb for Appellee Board of Trustees of the National Elevator Industry Health Benefit Plan.
11/25/2014	Judgment entered as to Appellant Robert Montanile.
11/25/2014	Opinion issued by court as to Appellant Robert Montanile. Decision: Affirmed. Opinion type: Non-Published. Opinion method: Signed.
12/01/2014	Oral argument CD requested by Kristina Kourasis.
12/19/2014	Notice of Writ of Certiorari filed as to Appellant Robert Montanile. SC# 14-723.
01/02/2015	Mandate issued as to Appellant Robert Montanile.
01/29/2015	Checked status of certiorari 14-723 filed as to Appellant Robert Montanile Pending.
03/24/2015	Checked status of certiorari 14-723 filed as to Appellant Robert Montanile Pending.
03/30/2015	Writ of Certiorari filed as to Appellant Robert Montanile is GRANTED. SC# 14-723.--[Edited 04/03/2015 by JC]

04/03/2015	Public Communication: The attorneys and Judge Brannon are being notified that the docket has been corrected to reflect that the U.S. Supreme Court has granted the petition for writ of certiorari.
05/06/2015	Checked status of certiorari 14-723 filed as to Appellant Robert Montanile Pending.
06/08/2015	Checked status of certiorari 14-723 filed as to Appellant Robert Montanile Pending.

THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Civil Action No. 12-cv-80746
Middlebrooks/Brannon

[Filed August 27, 2013]

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,	)
Plaintiff,	)
v.	)
ROBERT MONTANILE,	)
Defendant.	)

[ECF No. 35]

DEFENDANT ROBERT MONTANILE'S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF HIS MOTION FOR SUMMARY JUDGMENT

Defendant Robert Montanile ("Montanile"), through his undersigned counsel and pursuant to Federal Rule of Civil Procedure 56 and Local Rule 56.1, submits the following Memorandum of Points and Authorities in Support of his Motion for Summary Judgment in the above captioned matter.

STATEMENT OF UNDISPUTED MATERIAL FACTS

Pre-Litigation Factual Background

1. In 2008, Montanile was a participant in the National Elevator Industry Health Benefit Plan ("the Plan"). Plaintiff's Complaint, docket entry #1, ¶ 8; Defendant's Answer, docket entry #11, ¶ 8.

2. On December 1, 2008, Montanile was involved in an automobile accident in which he suffered serious injuries. Plaintiff's Complaint, docket entry #1, ¶ 9; Defendant's Answer, docket entry #11, ¶ 9.

3. The Plan provided coverage for some of Montanile's medical treatment following the accident in the amount of $121,044.02. Plaintiff's Complaint, docket entry #1, ¶ 10; Defendant's Answer, docket entry #11, ¶ 10.

4. Montanile subsequently pursued a negligence claim against the driver of the other vehicle involved in the accident. Montanile also filed an underinsured motorist claim with his own automobile insurer. Plaintiff's Complaint, docket entry #1, ¶ 13; Defendant's Answer, docket entry #11, ¶ 13.

5. Montanile settled both the negligence and underinsured claims. Plaintiff's Complaint, docket entry #1, ¶ 14; Defendant's Answer, docket entry #11, ¶ 14.

6. Montanile retained Brian S. King, Esq. ("King") to assist him in addressing the Plan's claim for reimbursement. Declaration of Brian S. King ("King Dec."), ¶ 3.

7. Thereafter King and counsel for the Plan, Kejo Bryan-Carby, exchanged a series of letters in which King requested information and documents to verify the validity of the subrogation claim. King Dec., ¶4

8. King requested all documents under which the Plan was established and operated, the Summary Plan Description ("SPD"), and all other documents outlining the rights and obligations of the parties. King Dec., ¶5.

9. Eventually the Plan sent to King various documents including the National Elevator Bargaining Association Agreement with International Union of Elevator Constructors, the Restated Agreement and Declaration of Trust National Elevator Industry Welfare Plan, and the SPD. King Dec., ¶6. These documents are attached as Exhibits A, B, and C to the King Dec.

10. King wrote Ms. Bryan-Carby on November 30, 2011, informed her that he did not believe the governing plan documents provided the Plan with any subrogation rights and asked that she produce a governing plan document containing language that entitled the Plan to assert its subrogation claim. King Dec. ¶¶7-8.

11. King indicated that if the Plan did not respond by December 14, 2011, he intended to disburse the settlement funds to Montanile. King Dec. ¶8.

12. The Plan responded on December 12, 2011, and maintained its position that the SPD, which contains subrogation language for the Plan, was the governing plan document. The Plan provided an

amount for which it was willing to settle the case. King Dec. ¶9.

13. King responded on December 13, 2011, reiterated Montanile's position that the Plan was not entitled to any subrogation recovery because the SPD language was not based on any governing plan document language, and rejected the Plan's offer of settlement. He provided a counteroffer to resolve the matter. King Dec. ¶10.

14. The Plan rejected Montanile's counteroffer and provided a final counteroffer of its own. The Plan stated that failure to accept its final offer would result in litigation. King Dec., ¶11.

15. On January 6, 2012, King wrote and requested that if the Plan intended to litigate the matter, it do so within 14 days. He stated that he would release the funds to Montanile if he had not been served with the Plan's Complaint by January 20, 2012. King Dec., ¶12.

16. The Plan did not respond to the letter and King's office disbursed the funds to Montanile on February 2, 2012. King Dec., ¶13.

17. The Plan did not file suit until July 11, 2012. Complaint, docket entry #1.

18. Montanile has paid and incurred obligations to pay King on an hourly basis for King's legal services. King Dec., ¶15.

19. Terms Relating To Subrogation In The Governing Plan Documents

20. The collective bargaining agreement attached as Exhibit A(1) and (2) to the King Dec., states in its first paragraph:

21. The Health Benefit Plan covering life insurance, sickness and accident benefits, and hospitalization insurance, or any changes thereto that are in accordance with the National Elevator Industry Health Benefit Plan and Declaration of Trust, shall be a part of this Agreement and adopted by all parties signatory thereto.

22. There is nothing in the collective bargaining agreement about any right to subrogation or reimbursement for the Plan from its participants.

23. The Restated Agreement and Declaration of Trust attached as Exhibit B(1), (2) and (3) to the King Dec., contains no language relating to any right of the Plan to obtain reimbursement or subrogation against its participants' third party recoveries.

OVERVIEW

The Board of Trustees of the National Elevator Industry Health Plan ("the Plan") relies on language in the Summary Plan Description ("SPD") to establish Montanile's obligation to reimburse the Plan for medical expenses it paid arising out of his workplace injury. It is undisputed that the only document containing any language giving the Plan the right to any subrogation or reimbursement claims against Montanile is the SPD. However, the only two documents that reflect the actual agreement between the management team for the employers and the employees' union representing Montanile are the National Elevator Bargaining Association Agreement

with International Union of Elevator Constructors ("Bargaining Association Agreement" attached as Exhibit A to the King Dec.) and the Restated Agreement and Declaration of Trust for the National Elevator Industry Welfare Plan ("Restated Agreement and Declaration of Trust" attached as Exhibit B to the King Dec.). Neither of these governing plan documents contain any language establishing any subrogation or reimbursement right on behalf of the Plan. Contrary to the Plan's argument, the SPD cannot create a right to subrogation or reimbursement to which the parties to the underlying agreement, management and the employees, have never agreed. Consequently, Montanile is entitled to this Court's entry of Summary Judgment in his favor and to an award of attorney fees and costs incurred in defending against the Plan's improper reimbursement claim.

ARGUMENT

I. THE GOVERNING PLAN DOCUMENTS DO NOT PROVIDE THE PLAN WITH ANY RIGHTS OF SUBROGATION OR REIMBURSEMENT

The Bargaining Association Agreement and the Restated Agreement and Declaration of Trust are the only documents that were negotiated between the employers and the employee union. Those documents establish the rights and obligations between the parties. They are silent about the subrogation and reimbursement rights for the Plan. ERISA requires that each employee welfare benefit plan sponsor prepare a summary of the benefits for ERISA plan participants and beneficiaries. 29 U.S.C. §1021. This SPD is required to contain the material outlined in 29

U.S.C. §1022 and to be furnished to ERISA plan participants. 29 U.S.C. §1024. But, by definition, the SPD is a summary of other governing plan documents. The Plan may not create subrogation and reimbursement rights out of thin air, unilaterally place them in the SPD, and insist that this Court enforce those rights.

Two years ago, in Cigna Corp. v. Amara, 131 S.Ct. 1866 (2011), the Supreme Court discussed at some length the relationship between documents that establish the rights and obligations of the parties to an ERISA plan and the SPD. The Court made clear that SPDs are not terms of an ERISA Plan. Amara, 131 S.Ct. at 1877. ". [T]he summary documents, important as they are, provide communication with beneficiaries *about* the plan, but their statements do not themselves constitute the *terms* of the plan for purposes of §502(a)(1)(B) [29 U.S.C. §1132(a)(1)(B)]." Amara, 131 S.Ct. at 1878 (emphasis in original). If there is inconsistency between the terms of the SPD and the terms of the documents that establish the rights and obligations between the parties and govern their relationship, the SPD must yield. Id.

In this case, the Plan's reimbursement claim is brought under 29 U.S.C. §1132(a)(3) rather than §1132(a)(1)(B). But this makes no difference. Under 29 U.S.C. §1132(a)(3) the Plan is entitled to obtain only "appropriate equitable relief to enforce the terms of the plan." The Supreme Court has made clear that, based on this statutory language, any claim for reimbursement or subrogation is both equitable in nature and must be based on the terms of the ERISA

plan. U.S. Airways v. McCutchen, 133 S.Ct. 1537 (2013).

In McCutchen an ERISA plan fiduciary brought a reimbursement claim against a plan participant based on clear language allowing for reimbursement found in the SPD in that case.[1] The Court made clear the language of 29 U.S.C. §1132(a)(3) requires the parties to live with the terms of the governing plan documents when evaluating the rights and obligations of the parties dealing with reimbursement claims. McCutchen, 133 S.Ct. at 1546 (equitable principles are "'beside the point' when parties demand what they bargained for in a valid agreement" (citing Sereboff v. Mid Atlantic Medical Services Inc., 547 U.S. 356 (2006)). Relying on 29 U.S.C. §1104(a)(1)(D), the Court pointed out that ERISA plans must be established and maintained pursuant to written documents and that ERISA fiduciaries must act in accordance with those documents: "[t]he plan, in short, is at the center of ERISA." McCutchen, 133 S.Ct. at 1548. And Amara makes clear that the SPD is an entirely separate

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[1] Only at the Supreme Court level of argument, in response to a request from the Solicitor General, did the Plan produce the governing plan document. The Supreme Court refused to consider the argument that the SPD language was not controlling in light of inconsistent language in the governing plan document only because the argument was raised too late in the process. "Because everyone in this case has treated the language from the summary description as though it came from the plan, we do so as well." McCutchen, 133 S.Ct. at 1543, n.1. This aspect of McCutchen highlights the importance of the governing plan documents, rather than the SPD, determining the rights and obligations of the parties with regard to reimbursement claims.

document from the agreement between the parties that constitutes "the plan."

The governing plan documents, the Bargaining Association Agreement and the Restated Agreement and Declaration of Trust, are the only contracts negotiated by the parties to the Plan. Neither make any reference to, or create any rights for, subrogation or reimbursement in the Plan. The language of the SPD may not stand alone. Montanile is entitled to Summary Judgment in his favor on the Plan's cause of action.

II. MONTANILE IS ENTITLED TO AN AWARD OF ATTORNEY FEES AND COSTS UNDER 29 U.S.C. §1132(g)

In his Answer filed in this case Montanile requested an award of attorney fees and costs for the expenses incurred in defending against the Plan's action against him. The basis for his request is the language of 29 U.S.C. §1132(g)(1) which states that in an ERISA case the court, in its discretion, may allow a reasonable attorney fee and costs to either party. In Hardt v. Reliance Standard Life Ins. Co., 130 S.Ct. 2149 (2010), the Court interpreted this provision of ERISA as allowing an award of attorney fees and costs where a litigant realizes "some degree of success on the merits" in the litigation. Hardt, 130 S.Ct. at 2158. There can be little question that a ruling in Montanile's favor on summary judgment constitutes "some degree of success on the merits" of this case.

The Supreme Court also left open the option for federal courts to utilize the five factor test that was commonly employed for evaluating an award of

attorney fees under ERISA before Hardt was decided. The Eleventh Circuit version of that analysis initially was provided in McKnight v. Southern Life & Health Ins. Co., 758 F.2d 1566 (11th Cir. 1985) and has since been cited in many cases. The five factors are (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorney's fees; (3) whether an award of attorney's fees against the opposing parties would deter other persons acting under similar circumstances; (4) whether the parties requesting attorney's fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties' position. McKnight, 758 F.2d at 1571-72. "In applying these criteria, courts should bear in mind ERISA's essential remedial purpose: to protect the beneficiaries of [ERISA] plans." Nachwalter v. Christie, 801 F.2d 956, 962 (11th Cir. 1986).

With regard to the first factor, given the complete absence of any language in the documents governing the parties and creating rights and obligations between them, Montanile believes the Plan is acting in a culpable manner in pursuing him for reimbursement. In addition, in light of his attempts to negotiate a resolution of this matter short of litigation and the Plan's delay in bringing suit until months after all the settlement money had been disbursed to Montanile, the actions of the Plan in pursuing Montanile may at least be labeled as culpable.

With regard to the second factor, there can be little question that the Plan has the capacity to satisfy an award of attorney fees in favor of Montanile. The same

cannot be said for any claim for attorney fees by the Plan against Montanile.

With regard to the third factor, an award of attorney fees against the Plan would send a clear message to ERISA fiduciaries holding subrogation or reimbursement claims: if you pursue plan participants for reimbursement when the governing plan documents give you no right to do so, you will pay the costs associated with the participant's defense of that litigation when and if a Court rules in favor of the participant. That is a message that needs to be sent to and received by plan fiduciaries in order to prevent harassment of participants.

With regard to the fourth factor, while the case is being defended only by Montanile on his own behalf, an award of fees to Montanile will have a beneficial effect on all plan participants who seek some protection against being pursued by plan fiduciaries for reimbursement despite the fact that no legal basis exists for these collection efforts. This case also involves an important legal issue that has not been dealt with in the Eleventh Circuit since Amara and McCutchen were decided: the extent to which ERISA plans can collect reimbursement based on SPD language when the governing plan documents are silent in establishing any right to reimbursement.

With regard to the fifth factor, the relative merits of the parties positions are outlined in the argument section in Point I above. Montanile believes this weighs strongly in his favor in this case.

In the event this Court grants Montanile's Motion for Summary Judgment he requests the opportunity to

present more specific information about the amount of attorney fees and costs he will have incurred at the time of the Court's ruling.

* * * [Certificate of Service omitted]* * *

THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Civil Action No. 12-cv-80746
Middlebrooks/Brannon

[Filed August 27, 2013]

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Plaintiff,

v.

ROBERT MONTANILE,

Defendant.

[ECF No. 35-2]

DECLARATION OF BRIAN S. KING

I, BRIAN S. KING, make the following Declaration:

1. I am over 18 years of age, I am competent to make this Declaration and I have personal knowledge of the matters attested to.

2. I am one of the attorneys for the Defendant, Robert Montanile, in the above captioned matter and I am a member in good standing of the Utah State Bar. I have been admitted *pro hac vice* to proceed in this matter in the Southern District of Florida.

3. Robert Montanile ("Montanile") retained my law firm to assist him in connection with a claim for reimbursement ("subrogation claim") being asserted by the National Elevator Industry Health Benefits Plan ("the Plan") of benefits paid by the Plan for Montanile's medical care and treatment following an automobile accident in December of 2008.

4. After Montanile retained my office, counsel for the Plan, Kejo Bryan-Carby, and I exchanged a series of letters in which I requested information and documents to verify the validity of the subrogation claim.

11. The Plan rejected Montanile's counteroffer and provided a final counteroffer of its own. The Plan stated that failure to accept its final offer would result in litigation.

12. I wrote a letter to the Plan on January 6, 2012 and requested that if the Plan intended to litigate the matter, it do so within 14 days. I stated that I would release the funds to my client if I had not been served with the Plan's Complaint within that time frame.

13. The Plan did not respond to my letter. My office disbursed the funds to Montanile on February 2, 2012.

14. The next communication from the Plan to me or action taken by the Plan was when I was informed that the Plan had filed its Complaint in this case in July, 2012.

15. Montanile has paid me and incurred obligations to pay me on an hourly basis for my legal work in this case.

Under penalty of perjury, and pursuant to 28 U.S.C. § 1746, I swear that the foregoing is true and correct.

DATED this **27th** day of **August, 2013**.

/s/_____
Brian S. King
Attorney for Defendant Robert Montanile

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

CASE NO. 12-80746-CIV
BRANNON

[Filed August 27, 2013]

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,	)
Plaintiff,	)
v.	)
ROBERT MONTANILE,	)
Defendant.	)

[ECF No. 36]

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND MEMORANDUM OF LAW IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT

Comes now the Plaintiff, Board of Trustees of the National Elevator Industry Health Benefit Plan (hereafter, the "Board of Trustees"), and moves this Court for Summary Judgment in its favor and files this Memorandum of Law in support of its Motion for Summary Judgment.

UNDISPUTED MATERIAL FACTS

Plaintiff sets forth the following facts of the case which it believes are undisputed by the Parties, as acknowledged by Defendant's answer filed in this action (Document 11 in the Court's file):

1. The Board of Trustees is the named fiduciary and administrator of the National Elevator Industry Health Benefit Plan (hereafter, the "NEI Plan" or "Plan"), as defined in Sections 402(a) and 3(16)(A) of the Employee Retirement Income Security Act of 1974 (hereafter "ERISA"), (29 U.S.C. §§ 1102(a) and 1002(16)(A)). McGowan Affidavit Exhibit B, p. 83.

2. The NEI Plan is a self-funded, multiemployer, employee welfare benefit plan as defined by ERISA. Complaint ¶ 2, Answer ¶ 2.

3. The NEI Plan was established and is maintained in accordance with its Restated Agreement and Declaration of Trust (hereafter the "Trust Agreement") and is administered by the Board of Trustees at 19 Campus Boulevard, Newtown Square, Pennsylvania. Complaint ¶ 2, Answer ¶ 2.

4. Under the terms of the Trust Agreement, the Trustees are required to establish the Plan of Welfare Benefits (hereafter the "Plan of Benefits") which is the detailed basis on which payment of benefits is to be made pursuant to the Trust Agreement and which sets forth eligibility requirements, type, amount and duration of benefits that are to be provided to participants. McGowan Affidavit Exhibit A, Article

5. In accordance with this authority, the Board of Trustees has adopted and from time to time has

amended and restated the National Elevator Industry Health Benefit Plan Summary Plan Description, which is the Plan of Welfare Benefits authorized in the Trust Agreement. McGowan Affidavit ¶ 7

6. The Board of Trustees has drafted the Plan of Benefits so that it also comports to the statutory and regulatory requirements of a "summary plan description" as that term is defined in Section 102 of ERISA (29 U.S.C. § 1022) and 29 C.F.R. §2520.102. McGowan Affidavit ¶

7. All amendments, modifications and restatements of the National Elevator Industry Health Benefit Plan Summary Plan Description are approved by the Board of Trustees. McGowan Affidavit ¶ 7.

8. At all times relevant to this action, Defendant was a participant in the NEI Plan. Complaint ¶ 8, Answer ¶ 8.

9. On or about December 1, 2008, Defendant sustained personal injuries in an automobile accident. Complaint ¶ 9, Answer ¶ 9.

10. The NEI Plan has paid medical benefits of at least $121,044.02 to or on behalf of Defendant for treatment of injuries sustained in the December 1, 2008 accident. Complaint ¶ 10, Answer ¶ 10.

11. The Plan Benefits contains certain recovery/ reimbursement language as set forth in Exhibit A attached to Plaintiff's Complaint (pages 1 of 2 and 2 of 2 of Document 1-1 in Court's file). Complaint ¶ 12, Answer ¶ 12.

12. Defendant filed a negligence claim against driver causing the accident referenced in paragraph 7 above, as well as a claim for uninsured motorist benefits under his own automobile insurance coverage. Complaint ¶ 13, Answer ¶ 13.

13. Defendant has settled the claims referenced in paragraph 7 above for a total of $500,000. Complaint ¶ 14, Answer ¶ 14.

14. All or part of the proceeds realized from the settlement of the claims referenced in paragraph 10 above are within Defendant's actual or constructive possession. Complaint ¶ 15, Answer ¶ 15.

15. Defendant has not reimbursed the Plan from the proceeds of the settlement of the claims referenced in Paragraph 10 above. Complaint ¶ 16, Answer ¶ 16.

* * *

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

CASE NO. 12-80746-CIV
BRANNON

[Filed August 27, 2013]

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Plaintiff,

v.

ROBERT MONTANILE,

Defendant.

[ECF No. 36-1]

AFFIDAVIT IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

I, JOHN A. MCGOWAN, under penalties for perjury, attest to the following facts as true and accurate and within the scope of my personal knowledge.

1. I am an adult over eighteen (18) years of age and am competent to testify as to the matters alleged herein.

2. I make this affidavit based on personal knowledge of all of the facts and allegations contained herein.

3. At all times relevant to this matter, I have been employed by the National Elevator Industry Benefit Plans as the Director of Health Claims Administration.

4. The National Elevator Industry Health Benefit Plan ("NEI Plan" or "Plan") was established by a Restated Amendment and Declaration of Trust ("Trust Agreement") which is attached hereto as Exhibit A.

5. Pursuant to Article VII of the Trust Agreement, the Trustees are required to establish the Plan of Welfare Benefits which, among other things, sets forth the detailed basis on which payment of benefits is to be made pursuant to the Trust Agreement.

6. Pursuant to Article VII of the Trust Agreement, the Trustees are granted full discretionary authority to adopt the Plan of Welfare Benefits setting forth the eligibility requirements, type, amount, and duration of benefits that are to be provided to eligible employees.

7. The Board of Trustees, pursuant to this authority, approved the current National Elevator Industry Health Benefit Plan Summary Plan Description as the Plan of Welfare Benefits governing the operation of the National Elevator Industry Welfare Plan at their regular meeting on September 8–9, 2004. The National Elevator Industry Health Benefit Plan Summary Plan Description is attached hereto as Exhibit B. Since adopting the latest National Elevator Industry Health Benefit Plan Summary Plan Description, the Trustees have adopted several

amendments to this document at regular meetings of the Board of Trustees in compliance with Article VII, Paragraph 3 and Article IV of the Trust Agreement.

8. The Board of Trustees intends and the Plan is administered so that the National Elevator Industry Health Benefit Plan Summary Plan Description serves as both the written plan and the summary plan description, and it is the formal plan document that sets forth the rights and benefits of Plan participants and their eligible dependents.

9. The National Elevator Industry Health Benefit Plan Summary Plan Description is the only document that sets forth eligibility requirements, type, amount and duration of benefits that are to be provided to participants and their eligible dependents.

10. The National Elevator Industry Health Benefit Plan Summary Plan Description contains an "Other Party Liability Claims" section that assigns the National Elevator Industry Health Benefit Plan a first right from the proceeds that a Covered Person receives from third party liable for their medical expenses. The Board of Trustees included this provision in this plan document to help preserve the assets of the NEI Plan.

11. In accordance with the National Elevator Industry Health Benefit Plan Summary Plan Description, Robert Montanile signed a written acknowledgement on August 5, 2009 acknowledging the Plan's right to recovery in accordance with the Plan's "Other Party Liability Claims" provisions which is attached hereto as Exhibit B.

12. In accordance with its fiduciary duty to enforce the terms of the NEI Plan and preserve finite

assets of the NEI Plan, the Trustees, through their agents, have requested Robert Montanile to reimburse the Plan for medical expenses paid on his behalf from the proceeds of his $500,000 settlement with third parties. To date, Robert Montanile has refused to honor his obligation under the NEI Plan.

FURTHER AFFIANT SAYETH NOT.

I AFFIRM UNDER THE PENALTIES FOR PERJURY THAT THE FOREGOING REPRESENTATIONS ARE TRUE AND CORRECT.

Date: 8/27/2013 /s/_____
(Affiant's Signature)

COMMONWEALTH OF PENNSYLVANIA
COUNTY OF Delaware)

Subscribed and SWORN to before me,
This 27th day of August, 2013.

/s/_____
NOTARY PUBLIC

My Commission expires: 1-27-14

[SEAL]

[ECF No. 36-4]

[pp.71-72]

Summary Plan Description / Coordination of Benefits (as of May 2011)

* * *

OTHER PARTY LIABILITY CLAIMS

The Plan's Right of Recovery

The Plan has the right to recover benefits advanced by the Plan to a covered person for expenses or losses caused by another party. If a covered person is injured or becomes ill under circumstances where another party is directly or indirectly liable for the illness or injury, the Plan is only obligated to provide covered benefits resulting from that illness or injury that exceed any amounts recovered from another party (whether or not the amount recovered is designated to cover medical expenses).

Amounts that have been recovered by a covered person from another party are assets of the Plan by virtue of the Plan's subrogation interest and are not distributable to any person or entity without the Plan's written release of its subrogation interest. However, amounts recovered by such covered person from another party in excess of benefits paid by the Plan are the separate property of such covered person. Unless otherwise noted in this SPD, amounts received from an individual health insurance policy for which the injured covered person or other family member has paid premiums are also the separate property of the covered person.

Amounts received from a personal homeowners insurance policy, an automobile insurance policy or a group insurance arrangement of any kind, regardless of whether the injured covered person or other family member has paid premiums, are considered a payment from another party and are subject to the Plan's right of recovery hereunder.

The Plan's right of recovery also applies if benefits are advanced by the Plan to an individual acting on behalf of an injured covered person or to the covered person's assignee.

The Plan's Right of Reimbursement

The Plan has a right to first reimbursement out of any recovery. Acceptance of benefits from the Plan for an injury or illness by a covered person, without any further action by the Plan and/or the covered person, constitutes an agreement that any amounts recovered from another party by award, judgment, settlement or otherwise, and regardless of how the proceeds are characterized, will promptly be applied first to reimburse the Plan in full for benefits advanced by the Plan due to the injury or illness and without reduction for attorneys' fees, costs, expenses or damages claimed by the covered person, and regardless of whether the covered person is made whole or recovers only part of his/her damages.

Acceptance of benefits from the Plan for an illness or injury by a covered person constitutes the covered person's agreement to file a claim for benefits against any party who is liable for the injury or illness to the covered person and to file claims under any and all applicable policies of insurance or self-insurance, including but not limited to homeowners insurance,

auto insurance, or any liability policy held for a public or commercial entity. The covered person must promptly file a claim for damages against any party liable and any such applicable policy and notify the Plan of his/her claim against such parties or policies or other recovery efforts. The covered person agrees that neither he/she nor anyone acting on his/her behalf will settle any claim relating to the injury or illness without the written consent of the Plan. The Plan reserves the right to make all decisions with respect to its rights of subrogation and recovery.

Acceptance of benefits from the Plan for an illness or injury by a covered person constitutes the covered person's agreement to assist the Plan in prosecuting any rights, interests, claims, or causes of action that have been assigned to the Plan against another party, including, if requested by the Plan, the institution of a legal proceeding against another party or any insurer or recipient of Plan assets improperly distributed without the written consent of the Plan.

Acceptance of benefits from the Plan for an illness or injury by a covered person constitutes authorization for the Plan to sue, compromise or settle, in the covered person's name or otherwise, all rights, claims, interests or causes of action to the extent of benefits advanced.

Acknowledgement Form

Prior to advancement of a benefit by the Plan to a covered person under this section for any expense or loss for which there may be a claim against another party, a covered person must execute a written document acknowledging the Plan's right of recovery as set forth in this section and must provide information

including the expense or loss for which another party may be liable and insurance coverage.

Failure to Execute Acknowledgement Form
Even if no Acknowledgement Form is sent by the Plan or sent but not signed, based solely upon the Plan's advancement of benefits, the Plan has a subrogation and reimbursement interest in the amount recovered, or to be recovered, by the covered person for the entire amount advanced by the Plan for the claim, even if the covered person does not execute the Acknowledgement Form. The covered person must promptly notify the Plan of any recovery from any source.

Claimant's Failure to Reimburse
Should it be necessary for the Plan to institute legal action against the covered person for failure to return Plan assets, in full, or to honor the Plan's interest in the amount recovered by the covered person from another party, the Plan may bring suit against the covered person and such covered person is liable for all of the Plan's costs of collection, including reasonable attorneys' fees and costs.

Right to Withhold Future Benefits
The Plan has the right to treat any benefits provided as an advance and to deduct such amounts from future benefits to which the covered person or an immediate covered family member may otherwise be entitled until the amount due the Plan has been satisfied. Such amounts may be deducted from amounts due third party medical providers despite any certification of Plan coverage that may have been provided to these providers.

Failure to Notify the Plan of Possible Other Party Liability

The Plan has all rights specified in this section in the event that a covered person fails to inform the Plan that another party may be Liable for the covered person's illness or injury and the Plan pays any benefits arising from that illness or injury.

Definition of "Party"

For purposes of this section "party" is defined to include, but is not limited to, any of the following:

- The party or parties that caused the illness, sickness or bodily injury;
- The insurer or other indemnifier of the party or parties who cause the illness, sickness or bodily injury;
- A guarantor of the party or parties who caused the illness, sickness or bodily injury;
- A worker's compensation insurer; and/or
- Any other person, entity, policy or plan that is liable or legally responsible in relation to the illness, sickness or bodily injury.

* * *

[ECF No. 36-5]

NATIONAL ELEVATOR INDUSTRY BENEFIT PLANS

19 CAMPUS BLVD., SUITE 200, NEWTOWN SQUARE, PA 19073-3288
TOLL FREE 1-800-252-4611
FAX 810-557-4655
WWW.NEIBENEFITS.ORG

REIMBURSEMENT AGREEMENT/WORKERS COMPENSATION CLAIMS ONLY

Name: *Robert J. Montanile*

Member ID: *NEI 801077495*

Date of Injury/Illness: *12-01-2008*

Has a Workers Compensation Claim been filed?
YES NO

If no, please explain: *Injured my neck and lower back*

Has your Workers Compensation Carrier accepted liability on your claim? YES NO
* *paid medicals denied weekly benefits*

If your Workers Compensation Claim was denied, have you filed an appeal? YES NO

As a covered member under the National Elevator Industry Health Benefit Plan ("Plan"), I acknowledge receipt of payment of expenses incurred as a result of a work related injury/illness as described above.

I hereby acknowledge the Subrogation provisions of the Plan's Summary Plan Description. In accordance with

Plan provisions, I agree to reimburse, in full, the National Elevator Industry Health Benefit Plan to the extent of any recovery for said expenses made by my Workers Compensation Carrier or as a result of any legal action or settlement or otherwise.

/s/ Robert J. Montanile (Signature of Employee) *8-5-09* (Date)

ACTION CANNOT BE TAKEN ON YOUR CLAIM(S) UNTIL ALL OF THE BELOW LISTED INFORMATION IS PROVIDED

1. Name of your Workers Compensation Carrier: *Gallagher Bassett*

   Claim Number: *011508022674WC01*

2. Workers Compensation Carrier Address: *1301 International Parkway #230, Sunrise, FL 33323*

3. Workers Compensation Carrier Telephone Number: *800-889-6764 – 954-846-1331 Debra Ribolini*

4. If your Workers Compensation Carrier denied your claim, or your claim is currently under review, please attach a copy of their determination.

   I had Judd Koenig as my attorney. As of 8-4-09, he is no longer my attorney. He can be reached at 561-626-3800

5. If you have filed an appeal with your Workers Compensation Carrier and you have retained an attorney to assist you with your appeal, please provide the attorney's name, address, and telephone number. If you have not retained an attorney to

assist you with your appeal, please indicate the same.

Please return this from with the supporting documents to the address listed above. Should you have any questions, please contact our Member Services Department at 1-800-252-4611.

PLEASE INCLUDE A COPY OF YOUR WORKERS COMPENSATION CARRIER'S DETERMINATION
COMPLETION OF THIS FORM DOES NOT GUARANTEE COVERAGE

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

Case No. 12-CV-80746-DLB

[Filed September 13, 2013]

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Plaintiff,

v.

ROBERT MONTANILE,

Defendant.

[ECF No. 38]

* * *

PLAINTIFF'S RESPONSE TO DEFENDANT'S STATEMENT OF UNDISPUTED MATERIAL FACTS

Plaintiff responds to the Defendant's Statement of Undisputed Material Facts as follows:

1. Plaintiff does not dispute the facts asserted in paragraphs 1 through 18 of the Defendant's Statement of Undisputed Material Facts.

2. Paragraph 19 of Defendant's Statement of Undisputed Material Facts does not state a factual allegation nor does it cite to the record. To the extent

that Paragraph 19 asserts a factual allegation, such allegation is neither undisputed nor material.

3. Paragraphs 20 and 21 of Defendant's Statement of Undisputed Material Facts appear to make only one allegation that attempts to quote language of the first paragraph of Exhibit A-1 and A-2 of the King Declaration (Docket Entry Nos. 35-3 and 35-4). With respect to the factual allegation, the Plaintiff disputes that the first paragraph of the Exhibit A-1 and A-2 contains the language cited in Paragraph 21. Such language is contained in Paragraph 1 of Article XVII (pg. 42) of Exhibit A-1 and A-2 of the King Declaration.

4. Plaintiff disputes Paragraph 22 of the Defendant's Statement of Undisputed Material Facts wherein it is indicated that nothing in the collective bargaining agreement ("CBA") addresses the right of subrogation or reimbursement. Paragraph 1 of Article XVII of the CBA adopts the language of the Health Benefit Plan and the Declaration of Trust into the CBA. The Health Benefit Plan contains rights of subrogation and reimbursement. *See* King Dec. Exhibit A-1 and A-2, p. 42 (Docket Entry Nos. 35-3 and 35-4); McGowan Affidavit Exhibit B-2, pp. 71-72 (Docket Entry No. 36-4).

5. Plaintiff does not dispute the facts asserted in Paragraph 23 of the Defendant's Statement of Undisputed Material Facts.

* * *

THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Civil Action No. 12-cv-80746
Middlebrooks/Brannon

[Filed September 25, 2013]

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Plaintiff,

v.

ROBERT MONTANILE,

Defendant.

[ECF No. 39]

DEFENDANT ROBERT MONTANILE'S MEMORANDUM IN OPPOSITION TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

Defendant Robert Montanile ("Montanile"), through his undersigned counsel and pursuant to Federal Rule of Civil Procedure 56 and Local Rule 56.1(a), submits his Memorandum in Opposition to Plaintiff's Motion for Summary Judgment.

RESPONSE TO PLAINTIFF'S UNDISPUTED MATERIAL FACTS

Montanile does not object to Plaintiff's undisputed facts contained in paragraphs 1, 2, 8, 9, 10, 12, 13, and 15. As to the remaining statements, Montanile provides his responses below.

3. Montanile denies that the Restated Agreement and Declaration of Trust ("Trust Agreement") is the only document under which the Plan is established and operated. The "Bargaining Association Agreement," attached as Exhibit A to the first Declaration of Brian S. King (previously submitted) is also a document under which the Plan is established and operated.

4. Montanile denies that there is any reference in paragraph 4 to the Article in the Trust Agreement relied on by the Plaintiff and attached as Exhibit A to the McGowan Affidavit. The language of the Trust Agreement speaks for itself.

5. Montanile denies that the Trust Agreement is the only controlling Plan document and denies that the Summary Plan Description is the Plan of Welfare Benefits referenced in the Trust Agreement.

6. Montanile denies that the Plan of Benefits complies with the requirements of 29 U.S.C. §1022 and 29 C.F.R. §2520.102, and denies that the Plan of Benefits is a controlling Plan document.

7. Montanile denies that any minutes, records or other documents have been presented to reflect adoption by the Board of Trustees of the subrogation and reimbursement language contained in the Summary Plan Description. Montanile denies that

information has been presented to him or this Court that allows for verification that the process identified in the Trust Agreement has been followed in adopting any subrogation or reimbursement language.

8. The language of the document attached as Exhibit A to the Plaintiff's Complaint speaks for itself.

14. Montanile denies that he is in actual or constructive possession of any but a small portion of the proceeds realized from the settlement of his claims.

DEFENDANT'S ADDITIONAL UNDISPUTED FACTS

1. Montanile was involved in a serious automobile accident in 2008. He was at work and was driving a work vehicle when a drunk driver ran a stop sign and hit Montanile. Declaration of Robert Montanile ("Montanile Dec."), filed concurrently herewith, ¶2.

2. Montanile suffered severe neck and back injuries in the accident which resulted in his having an L4-5 fusion with hardware inserted in his back. Montanile Dec., ¶3.

3. Montanile continues to experience physical limitations and ongoing pain from his accident related injuries. *Id.*

4. Montanile was scheduled for an additional back fusion surgery in 2012, but had to postpone that procedure as a result of complications with his heart condition. Montanile Dec., ¶4.

5. Sometime after the accident, Montanile retained an attorney to assist him in pursuing

compensation for his accident related injuries. The claim was litigated and eventually settled for payment to Montanile on $500,000. Montanile Dec., ¶5.

6. Payment for attorney fees and costs, medical expenses, other out-of-pocket expenses, and satisfaction of liens was made from the settlement proceeds. The amount left from the settlement for Montanile was approximately $90,000. Montanile Dec., ¶6.

7. Montanile is a single parent of a twelve-year old daughter. He has been the sole caretaker and custodian of his daughter since she was one year old. Montanile Dec., ¶7.

8. Following the personal injury settlement, Montanile spent several months attempting to negotiate a settlement with the Plaintiff in this case. The Plaintiff had asserted a subrogation or reimbursement claim for amounts the Plan had paid to cover some of Montanile's medical expenses. Montanile Dec., ¶8.

9. Montanile retained counsel to assist him in connection with the reimbursement claim. Montanile's counsel wrote to the Plan's agent and requested information to demonstrate the Plan's compliance with the anti-inurement provisions of ERISA. Second Declaration of Brian S. King ("2nd King Dec."), ¶¶1, 2.

10. The Plan's agent responded to the request and provided some requested materials. However, neither the Plan nor its agent has, to date, provided any information to document the Plan's

compliance with ERISA's anti-inurement terms. 2nd King Dec., ¶3.

11. Montanile and the Plan were unable to come to an agreement regarding the reimbursement claim and Montanile gave the Plaintiff a deadline to either settle the claim or file suit. Montanile Dec., ¶8.

12. The Plaintiff did not take any action either before the deadline or for a number of months following the deadline. Montanile requested and authorized disbursal of the remaining funds from the settlement. Montanile Dec., ¶9.

13. Montanile has used most of the remaining settlement funds to support himself and his daughter and to maintain their home. Montanile Dec., ¶6.

14. Montanile was served with the Plaintiff's Complaint in July of 2012. Montanile Dec., ¶10.

ARGUMENT

I. The Language of the SPD on which the Plan Relies is Not Effective in Creating a Valid Right to Subrogation or Reimbursement

For the reasons outlined in Montanile's Opening Memorandum, docket #35, pp. 5-7, the language of the Summary Plan Description ("SPD") upon which the Plan relies is ineffective in creating an enforceable right to subrogation or reimbursement in the Plan. Montanile will not repeat those arguments.

Montanile acknowledges that ERISA plan fiduciaries may draft a document that operates both as

the governing plan document and the SPD mandated by ERISA at 29 U.S.C. §§1021 and 1022. But that is not what the Plan in this case did. Rather, the Plan created the rights and obligations of the parties in the two documents attached to the Affidavit of Brian S. King submitted with Montanile's Opening Memo, the Bargaining Association Agreement and the Restated Agreement and Declaration of Trust.[1]

The Plan argues that the language of Article VII of the Restated Agreement and Declaration of Trust gives the Trustees discretionary authority to " adopt a Plan of Welfare Benefits, which sets forth eligibility requirements, type, amount, and duration of benefits that are to be provided to eligible employees .." The Plan then asserts that the SPD is that "Plan of Welfare Benefits" identified in the Restated Agreement and Declaration of Trust.

The problem with this argument is two-fold. First, there is nothing to suggest that this "Plan of Welfare Benefits" referred to is, or may be, independent of the rights and obligations laid out in the Restated Agreement and Declaration of Trust and the Bargaining Association Agreement. Nor is there anything in either governing plan document to indicate that the SPD provided by the Plan to this Court is the "Plan of Welfare Benefits" referred to in Article VII of

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[1] The Plan attached only the Restated Agreement and Declaration of Trust to its materials submitted in support of its Motion for Summary Judgment. The Bargaining Association Agreement is also a document governing the Plan. It specifically references both itself and the Restated Agreement and Declaration of Trust as being the documents that govern the Plan.

the Restated Agreement and Declaration of Trust. The Affidavit of John McGowan states in conclusory fashion that the SPD is the "Plan of Welfare Benefits" referred to in Article VII. But missing from the McGowan Affidavit is any attachment showing that the Trustees ever took action to adopt the SPD. There are no minutes, notes, or other documents showing that the SPD generally or, more specifically, the subrogation provisions of the SPD, were ever reviewed, and voted on, by the Trustees. It is insufficient for the Plan to simply say to this Court or Montanile, "just trust us" with regard to the *process* by which the reimbursement and subrogation provisions in the SPD were adopted.

The second problem for the Plan also ties into the process by which the subrogation and reimbursement language was supposedly adopted. Article VII of the Restated Agreement and Declaration of Trust requires that the "Plan of Welfare Benefits" be " based on what it is actuarially determined to be within the financial limitations of the National Elevator Industry Welfare Plan .." Par. 3 of Article VII, titled "Written Plan of Benefits," goes into more detail. It requires that the "Plan of Welfare Benefits" be modified only " by a resolution adopted by majority vote of all members of the Board of Trustees, following advice by the Actuary selected by the Trustees that any such amendment is actuarially within the financial limitations of the National Elevator Industry Welfare Plan."

In its brief, the Plan recognizes the importance of providing an actuarial basis for the language of the subrogation and reimbursement provision in the SPD. It asserts in its Opening Memorandum, p. 6, that "reimbursement and subrogation provisions are crucial

to the financial viability of self-funded plans" and that "denying the Plan reimbursement would harm other plan members and beneficiaries by reducing funds available to pay those claims'" (citation omitted). However, the authority the Plan cites for this assertion is not any actuarial data provided to the Trustees to be considered by them as part of their deliberations about what provisions should be included in the "Plan of Welfare Benefits." Rather, the Plan cites only to case law to support its argument. But that is not what Article VII requires.

The Plan's reimbursement provision takes money out of the pockets of participants and beneficiaries. Although nothing in ERISA prohibits the Trustees from placing a subrogation or reimbursement provision into governing plan documents, Article VII requires that all participant benefits provided, as well as limitations on those benefits, must be "actuarially based" and approved by a majority of the members of all members of the Board of Trustees. No evidence exists before this Court that this process occurred for the alleged adoption of any reimbursement language by the Plan. In light of the degree to which the efforts of the Plan against Montanile will damage his own ability to provide for himself and his daughter, the Plan may not ignore the procedural and substantive requirement of Article VII. Montanile and this Court are entitled, and the Plan should be required, to verify that the Plan based its reimbursement provision on an actuarial foundation as opposed to providing a windfall to the Plan at the expense of injured Plan participants such as Montanile.

The Plan has made no effort to demonstrate that it is complying with the requirements of ERISA that prohibit any assets of the plan inuring to the benefit of any person or entity other than the Plan. 29 U.S.C. §§1103(c); 1104(a)(1)(A) and (a)(1)(D); 1106(a) and (b) reference this prohibition. As noted in Montanile's Statement of Additional Undisputed Facts, ¶¶9 and 10, during correspondence in the pre-litigation process, Montanile requested assurance about, and evidence of, the fact that the money the Plan was seeking as reimbursement from Montanile would inure only to the benefit of the Plan and not to any other party. The Plan never responded to Montanile. Likewise, the Plan makes no effort as part of its Motion for Summary Judgment to provide any information about the disposition of any funds it seeks from Montanile and how those funds will be accounted for actuarially. The Plan is not free to take money out of Montanile's pocket without identifying who will receive those funds and how they will be accounted for in terms of promoting the actuarial soundness of the Plan.

The Plan argues that Montanile's obligation to reimburse the Plan is established or strengthened by Montanile's signature on a document attached as Exhibit C to the McGowan Affidavit. But that document is irrelevant to this claim. By its terms it relates only to the proceeds from Montanile's workers' compensation claim. It is undisputed that the funds at issue in this case are from Montanile's personal injury case, not his workers' compensation claim. In any event, the Plan cannot create new rights and obligations between the parties based on an after-the-fact agreement for which there was no consideration given by the participant.

II. The Plan's Reimbursement Claim is not "Appropriate Equitable Relief" Under the Terms of 29 U.S.C. §1132(a)(3) and the Facts of this Case

Finally, under the circumstances of this case, to allow the Plan to obtain the reimbursement it seeks from Montanile is not "appropriate equitable relief" as referred to in 29 U.S.C. §1132(a)(3). Although U.S. Airways v. McCutchen, 133 S.Ct. 1537 (2013) indicates that ERISA plan fiduciaries may enforce the terms of plan documents relating to subrogation and reimbursement claims, the phrase "appropriate equitable relief" has meaning. This Court should relieve the burden on plan participants to reimburse an ERISA plan when the Plan engages in a course of conduct that calls for "appropriate equitable relief." Those facts exist in this case.

Montanile's recovery did not make him whole. Montanile Decl., ¶¶5 and 6. The Plan has expressed no willingness to share in the significant attorney fees Montanile incurred in obtaining the personal injury settlement. Montanile has very little of the personal injury proceeds remaining in his possession in light of the nature of his injuries and his financial needs. Montanile Decl., ¶¶5-7. And, despite the Plan's allegation that it has identified a particular fund distinct from Montanile's general assets, this is not the case. There is no separate and distinct fund to which the proceeds of the personal injury case can be traced as required by Sereboff v. Mid Atlantic Medical Services, Inc., 126 U.S. 1869, 1875 (2006).

Finally, the Plan's collection agent in the pre-litigation process failed to act responsibly and

promptly in protecting the reimbursement interests of the Plan. As noted in Montanile's statement of additional undisputed facts, ¶¶9 and 10, the Plan failed to provide information requested by Montanile's counsel in the pre-litigation process to verify that ERISA's anti-inurement provisions would not be violated by repayment of any reimbursement to the Plan. In addition, as outlined in the Declaration of Brian S. King, ¶s 4-14, the Plan had an opportunity to protect its reimbursement claim either by settling that claim or by filing suit against Montanile promptly after it became clear that the case could not be resolved. But the Plan did neither. It also failed to take any action to identify the funds, determine if they were separate and identifiable from Montanile's assets and ensure that they would not be distributed to Montanile. Under those circumstances, Montanile should be relieved of any obligation that may otherwise exist to reimburse the Plan.

CONCLUSION

For the reasons set forth in this Memorandum, the Plaintiff's Motion for Summary Judgment should be denied and Montanile's Motion for Summary Judgment should be granted.

DATED this 25th day of September, 2013.

s/ Brian S. King
Brian S. King
John V Tucker
Attorneys for Defendant Robert Montanile

U.S. DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Civil Action No. 12-cv-80746
Middlebrooks/Brannon

[Filed September 25, 2013]

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Plaintiff,

v.

ROBERT MONTANILE,

Defendant.

[ECF No. 39-2]

SECOND DECLARATION OF BRIAN S. KING

I, BRIAN S. KING, make the following Declaration:

1. When I was originally retained by the Defendant, Robert Montanile, in this case, I wrote on June 6, 2011 to the agent for the Board of Trustees of the National Elevator Industry Health Benefit Plan ("the Plan"), Ms. Kejo Bryan-Carby. A copy of my June 6, 2011 letter to the Plan is attached hereto as Exhibit A.

2. In that letter, I requested that Ms. Bryan-Carby provide me with information demonstrating the

Plan's compliance with ERISA's anti-inurement provisions. Exhibit A, p. 3, ¶7.

3. Ms. Bryan-Carby responded to my letter and provided some information and documents as requested, but neither she nor the Plan has ever produced information or documents to provide proof of the Plan's compliance with ERISA;s anti-inurement terms.

Under penalty of perjury and pursuant to 28 U.S.C. § 1746, I swear that the foregoing is true and correct.

DATED this 25th day of September, 2013.

s/ Brian S. King
Brian S. King

* * * [First Exhibit A omitted] * * *

Exhibit A

Brian S. King
Attorney at Law

Brian S, King, Esq.
Via Certified Mail

336 South 300 East, Suite 200
Salt Lake City, Utah 84111
Telephone: (801) 532-1739
Toll Free: (866) 372-2322
Facsimile: (801) 532-1936
brian@briansking.com
www.erisa-claims.com

Linda A. Purdy, Paralegal
Mary E. Wardlaw, Paralegal

Via Certified Mail
Return Receipt Requested

June 6, 2011

Kejo Bryan-Carby
GIBSON & SHARPS
9390 Bunsen Parkway
Louisville, KY 40220

Re: Subrogation Claim of National Elevator Industry Health Benefit Plan
Insured: Robert Montanile

Dear Ms. Bryan-Carby:

I have been retained by Robert Montanile to assist in resolving the claimed subrogation interest of the National Elevator Industry Health Benefit Plan ("the Plan") against Mr. Montanile. I have reviewed some documents associated with the subrogation claim which have been provided to my office by Mr. Montanile and Robert Gordon, his personal injury attorney.

Before I am able to evaluate the ability of the Plan to assert any subrogation interest involving funds that may be paid to Mr. Montanile, I need to obtain additional information. Please provide to me the following information or documentation:

1. **Your authority:** I need documentation to verify the authority of any individual or entity acting on behalf of the Plan to assert the claim for subrogation and to collect amounts in connection with that claim from Mr. Montanile, I'm sure you understand why it would be inappropriate, perhaps a breach of fiduciary duty under 29 U.S.C. §1104(a), for me to facilitate the transfer of funds to anyone other than a plan fiduciary authorized to recover funds for the Plan. Only an ERISA fiduciary is authorized to bring a claim to impose an equitable lien or constructive trust on funds Mr. Montanile may recover from a third party. 29 U.S.C. §1132(a)(3). Please confirm in writing that you are a fiduciary within the meaning of 29 U.S.C. §1002(21). If you are not a fiduciary, please have the fiduciary who would be identified as the plaintiff in an action brought under 29 U.S.C., §1132(a)(3) for recovery of an equitable lien or constructive trust contact me. At the very least I need you to provide me with documentation from the fiduciary that clearly establishes your authority to act on behalf of the fiduciary. In addition, please provide me with all documents that provide a plan fiduciary with the authority to pursue a claim for subrogation or reimbursement on behalf of the Plan.

2. **Plan Documents**: Please provide me with the following plan documents:

    - The Summary Plan Description and other documents summarizing the rights and obligations of the parties under the Plan in effect for 2008, the year Mr. Montanile's accident occurred, to the present;

    - All documents under which the Plan was established;

    - All documents under which the Plan was operated from January 1, 2008, to the present. This includes any collective bargaining agreements, trust agreements, certificates of coverage, insurance policies or other documents which outline the rights and obligations of the parties at any time from January 1, 2008, to the present;

    - All contracts for administration or administrative services in connection with the processing, administration, claims handling, payment, or recoupment of payment associated with health benefits provided under the Plan in effect at any time from the date of Mr. Montanile's accident to the present;

    - All manuals, guidelines, policies, procedures, memoranda or other documents which the Plan, you, or any other fiduciary authored or relies upon relating to the handling of reimbursement or subrogation claims;

- All form 5500's, the annual reports, and any supplemental reports for the Plan, for all years from January 1, 2008, to the present;
- All contracts between the Plan and any entity insuring or indemnifying the Plan or any of its fiduciaries for any payments made by the Plan from January 1, 2008, to the present. The documents I request may be in the form of stop-loss insurance, excess loss insurance, reinsurance, certificates of coverage or any other contract, by whatever title, that provides insurance or reimbursement or indemnification for any portion of the Plan;
- To the extent there was any excess loss coverage, stop loss coverage, reinsurance, or other insurance coverage in place for any portion of the amounts paid by the Plan for any portion of the medical expenses incurred by Mr. Montanile for which the Plan asserts a reimbursement or subrogation claim, please provide an accounting of claims submitted and paid and a copy of any insurance policies.
- All insurance or other funding sources provided by or under the Plan for the benefit of Mr. Montanile from January 1, 2008.

3. **Identity of fiduciaries:** Please identify all named fiduciaries of the Plan along with their addresses, positions, and descriptions of their duties. Please also identify all unnamed fiduciaries (addresses, positions, descriptions of their duties) directly

involved in the processing, administration, claims handling, payment, or recoupment of payment associated with health benefits provided under the Plan from January 1, 2008, to the present.

4. **Documentation of payments:** Please provide a detailed statement of all monies paid on behalf of Mr. Montanile which you claim form any part of your claim for reimbursement, along with copies of all cancelled checks proving payment for those medical expenses.

5. **Contracts with health care providers:** Please provide copies of all contracts with health care providers under which the payments on behalf of my client was made, along with the statement and documentation regarding whether or not the plan received a rebate, discount, payback, or other benefit from any health care providers;

6. **Documentation of source of funds:** Please provide documentation and an explanation of the source of funds used by the Plan to make the payments that are the subject of your claim of reimbursement or subrogation including the identity of the insurer, organization, bank, or other entity holding the funds;

7. **Proof of compliance with ERISA's anti-inurement requirement:** As you are certainly aware, ERISA mandates that "the assets of a plan shall never inure to a benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and deferring reasonable expenses of administering the plan." 29

U.S.C. §1103(c). 29 U.S.C. §1104(a)(1) imposes the same limitation on the conduct of fiduciaries. Likewise, 29 U.S.C. §1106 strictly limits transactions for the use or benefit of a fiduciary or a party in interest. As such, please provide all documents setting forth the manner in which any funds which are recovered through subrogation or reimbursement claims are disposed of, including the identity of all individuals or entities who will receive any portion of those funds. Please also provide written assurance from all Plan fiduciaries that no portion of any recovered funds from Mr. Montanile will be used for any purpose other than to directly provide benefits to Plan participants and their beneficiaries.

The information and documents I have requested are necessary before we can engage in further dialogue regarding any potential reimbursement or subrogation claim the Plan may have. Each of the documents and pieces of information I have requested are essential to my ability to evaluate the basis of any subrogation or reimbursement interest the Plan may be asserting against Mr. Montanile. I will not be in a position to discuss this matter with you, or any other purported agent or fiduciary of the Plan, until and unless I receive the documents and information I have requested in this letter. If it is your position that you are not authorized, entitled or obligated to provide any portion of the information or documents requested in this letter, please identify the fiduciary or administrator to whom such requests should be directed within the next 20 days. Nothing in this letter should be read to constitute an agreement on behalf of

my client or myself that the Plan has a valid claim for reimbursement or subrogation.

The rights and remedies available to a Plan under ERISA are limited. Mr. Montanile reserves the right to raise any and all legal and equitable defenses available to him. These include laches, unclean hands, that no action may be brought to aid any enforcement of a forfeiture, and other equitable defenses. We also reserve the right to assert defenses based on the common fund doctrine and the made whole rule. As you are certainly aware, the Supreme Court in Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356 (2006), left open the question of whether the made whole rule must be taken into account in evaluating what is "appropriate equitable relief" authorized under 29 U.S.C. §1132(a)(3). Sereboff, 547 U.S. at 368, fn. 2.

I look forward to your prompt response to my questions.

Sincerely,

Brian S. King

BSK:lp

cc: Robert Montanile
Robert Gordon via email
(rgordon@fortheinjured.com)

THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Civil Action No. 12-cv-80746
Middlebrooks/Brannon

[Filed September 25, 2013]

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Plaintiff,

v.

ROBERT MONTANILE,

Defendant.

[ECF No. 39-3]

DECLARATION OF ROBERT MONTANILE

I, Robert Montanile, make the following Declaration:

1. I am the named Defendant in the above captioned matter.

2. In December, 2008, I was involved in a serious automobile accident in which I was hit by a drunk driver after he ran a stop sign. At the time of the accident, I was at work and was driving a work vehicle.

3. As a result of the accident, I had severe neck and low back injuries that led to an L4-5

fusion with hardware being placed in my back. I continue to have limitations and back pain. I have been given a permanent partial impairment rating of 25%.

4. My physician has recommended ongoing medical care in connection with my accident related injuries, including an additional fusion which was originally scheduled for 2012. That back surgery had to be postponed because of complications I was experiencing with a co-morbid heart condition.

5. Following the accident, I retained the services of a personal injury attorney to assist me in obtaining compensation for my injuries. I ultimately settled the case for payment of $500,000 after many months of litigation. Attached hereto as Exhibit A is a summary of the proceeds of the settlement and how they were disbursed. The amount recovered was not sufficient to compensate me for past and future medical expenses, past and future lost wages, losses associated with other out-of-pocket expenses, or compensation for my intangible losses.

6. After payment of attorney fees and costs, satisfaction of liens, medical expenses, and other expenses, the amount remaining from the settlement as compensation for my injuries was approximately $90,000. Most of that amount has been spent since the time of the settlement in supporting myself and my daughter and in maintaining our home.

7. I am the custodial single parent for my 12-year old daughter. I have been solely responsible for raising and supporting my daughter since she was one year old.

8. I spent several months following the settlement of my personal injury claim trying to negotiate a resolution of the reimbursement claim asserted by the Plaintiff, my former employer. I eventually set a deadline for the Plaintiff to either accept any amount I had offered to settle the claim or, in the alternative, to bring suit to enforce the reimbursement claim to allow me an opportunity to present to the Court my arguments about why I did not believe the Plaintiff was entitled to reimbursement under the terms of the Plan.

9. The deadline passed with no action from the Plaintiff and I authorized and requested distribution of the remaining funds by my attorneys.

10. Several months after the funds had been disbursed, I was served with the Plaintiff's Complaint.

Under penalty of perjury and pursuant to 28 U.S.C. § 1746, I swear that the foregoing is true and correct.

DATED this 24 day of September, 2013.

/s/
Robert Montanile

Exhibit A

Disbursement to: Robert Montanile		
Gross Proceeds from Negotiated Settlement:		$500,000.00
Less: Attorneys' fees in accordance with fee agreement-40%		
Lynn Waxman, Esq. (5%)	$25,000.00	
Gordon & Doner, P.A. (35%)	$175,000.00	
		($200,000.00)
Net Cash Proceeds before costs advanced:		$300,000.00
Less: Medical expenses:		($1,213.22)
Anesthesiology of Jupiter	$465.22	
West Palm Beach Fire Rescue	$398.00	
Mid Town Imaging	$416.89	
Life Watch	$300.00	
	Subtotal:	$298,786.78

Less Liens:		($146,189.02)
Blue Cross Blue Shield/Health Care Lien	$108,607.07	
Gallagher Bassett/ Workers Compensation Lien Balance of $28,296,00-Waived	$0.00	
Patrick & Peggy O'Hara	$10,360.00	
Joan Laurito	$11,000.00	
Funds R Us Loan Balance of $20,000.00 reduced to	$14,000.00	
State of CT /Child Support Lien	$1,325.55	
Union Dues	$896.40	
	Subtotal:	**$152,597.76**
Less: Client Costs Advanced: (See Attached) Balance of $69,797.54 reduced to		($63,788.48)
	Subtotal:	$88,809.28
Funds advanced to client on April 29, 2011		$58,884.39

Funds advanced to client on July 1, 2011		$1,628.89
Final Funds Available to Client:	$28,296.00	

THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Civil Action No. 12-cv-80746
Middlebrooks/Brannon

[Filed October 9, 2013]

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Plaintiff,

v.

ROBERT MONTANILE,

Defendant.

[ECF No. 40]

DEFENDANT ROBERT MONTANILE'S REPLY MEMORANDUM IN SUPPORT OF HIS MOTION FOR SUMMARY JUDGMENT

Defendant Robert Montanile ("Rob"), through his undersigned counsel and pursuant to Federal Rule of Civil Procedure 56 and Local Rule 56.1, submits the following Reply Memorandum in Support of his Motion for Summary Judgment in the above captioned matter.

ARGUMENT

Montanile's arguments regarding the fact that the governing plan documents do not contain language giving the Plan any subrogation or reimbursement

rights are outlined in Montanile's Opening Memorandum, docket #35, pp. 5-7, and Opposition Memorandum, docket #39, 4-8. Montanile will not repeat them here. However, the Plan's arguments do not refute Montanile's points.

The Plan argues that because the Restated Agreement and Declaration of Trust ("Trust Agreement") and the Bargaining Association Agreement do not flesh out all the details of the health benefit plan, the Summary Plan Description ("SPD") on which the Plan relies must govern the relationship. If the Trust Agreement and Bargaining Association Agreement were clear that the SPD would stand alone, perhaps the Plan's argument would hold water. But, in fact, the Trust Agreement does not contemplate the SPD to play such a role.

The Trust Agreement specifically refers to a "Plan of Welfare Benefits" that will be formulated by the parties. The Plan has never identified or produced this document. Either there is a document that exists but has not yet been produced by the Plan or, more likely, the Plan failed to adhere to the terminology used in the Trust Agreement and has simply utilized the SPD as the *de facto* "Plan of Welfare Benefits." The Plan goes on in its Opposition Memo to assert that because the SPD has all the components required of ERISA, it must be both the governing plan document as well as the SPD.

The problem for the Plan is that the Trust Agreement and the Bargaining Association Agreement contemplate more than the SPD, however it is denominated, to stand alone in establishing and defining the parties' rights and obligations. The Trust

Agreement, Article VII, Par. 1, states that the benefit plan must be "based on what it is actuarially determined to be within the financial limitations of the National Elevator Industry Welfare Plan." Par. 3 of Article VII goes on to require that any amendments to that benefit plan must likewise be " actuarially within the financial limitations of the National Elevator Industry Welfare Plan," must follow advice by "the Actuary selected by the Trustees," and must be adopted by a resolution approved by a majority of all the members of the Board of Trustees. No evidence that this occurred has ever been produced by the Plan.

The requirements in Article VII for benefits being based on actuarial principles is critical in this case because it is well established that any funds that may be recovered by the Plan must be used to fund plan benefits or the reasonable costs of administering the plan. 29 U.S.C. §§1103(c); 1104(a)(1)(A) and (a)(1)(D); 1106(a) and (b). These anti-inurement provisions of ERISA are in place to ensure that the assets of the plan are used for the benefit of the plan participants and beneficiaries. They work hand-in-glove with the actuarial requirements established in Article VII.

Both the anti-inurement and actuarial issues are critical in this case because it is well established that reimbursement of the type the Plan seeks in this case are simply windfalls. They are generally not actuarially accounted for in the establishment and quantity of health benefits. Edwin W. Patterson, *Essentials of Insurance Law*, § 33 (2d ed. 1957). Professor Patterson stated, "Subrogation is a windfall to the insurer. It plays no part in rate schedules." *Id.* at 151-52. *See also* Frost v. Porter Leasing Corp., 436 N.E.2d 387 390

(Mass. 1982) (denying subrogation by health insurer, stating "Subrogation played no part in the bargain between insurer and insured."); Maxwell v. Allstate Ins. Co., 728 P.2d 812, 815 (Nev. 1986) (denying subrogation on personally injury claim, stating "Allowing subrogation deprives the insured of the coverage for which he had paid and results in a windfall recovery for the insurer."); Kristin L. Huffaker, *Where the Windfall Falls Short: "Appropriate Equitable Relief" After* Sereboff, 61 Okla.L.Rev. 233, 248-49 (2008) ("Insurers consistently apply such recoveries to increasing dividends to shareholders."); Scott M. Aranson, *ERISA's Equitable Illusion: The Unjustice of Section 502(a)(3)*, 9 Emp.Rights& Emp.PolicyJ. 247, 289 ("Subrogation recoveries are used to increase executive compensation or shareholder dividends, not to decrease premiums."). Absent proof by the Plan that the ability to obtain the reimbursement it seeks in this case was part of the Plan's actuarial calculations in establishing benefits, the actuarial requirements of the language of Article VII dictate that the Plan's claim must fail.

At the very least the Plan must demonstrate that any recovery it obtains from Montanile will not run afoul of ERISA's anti-inurement provisions. Despite Montanile's repeated requests for this information in both the pre-litigation appeal process and in litigation, the Plan has never produced any information about the disposition of the funds it seeks from Montanile. This is not surprising in light of the fact that the most likely effect of collecting subrogation money will simply be to reduce the contribution from the employers that make up the Plan. That would be a violation of the anti-inurement provisions of ERISA and likely explains

why the Plan has never produced the repeatedly requested information about disposition of the reimbursement money. While U.S. Airways v. McCutchen, 133 S.Ct. 1537, 1547 (2013) holds that ordinarily the plan document language controls over equitable principles, nothing in McCutchen holds that the Plan may override ERISA's anti-inurement provisions. And, of course, logic dictates such a conclusion would gut the protections that Congress intended that statute would provide to participants and beneficiaries. The Plan's silence about the ultimate disposition of the funds it seeks from Montanile precludes its ability to collect those funds.

In short, the Plan may not recover anything from Montanile until and unless it provides assurances about the disposition of the money it seeks. Montanile asked for that information from the Plan before the funds held by his attorney were distributed to him. However, the Plan ignored Montanile and his counsel. Having stonewalled in the pre-litigation process, the Plan cannot belatedly come to this Court and provide that information. Montanile and his counsel relied on the Plan's failure to provide this information when they made the decision to disburse the funds out of Montanile's attorney's trust account. The Plan's time to provide assurances to Montanile that its reimbursement claim complied with ERISA's requirements came and went. The Plan now seeks something beyond "appropriate equitable relief" under 29 U.S.C. §1132(a)(3).

The plan relies on Alday v. Container Corp. of America, 906 F.2d 660 (11th Cir. 1990), and Ozarks Coco-Cola/Dr. Pepper Bottling Co., v. Ritter, 2011 U.S.

Dist. LEXIS 66686 (W.D. Mo. 2011) to support its argument that the SPD stands alone to establish the rights and liabilities of the parties in this case. But they are of no help to the Plan. In those cases the SPD was the only document that established plan terms. " [T]here is no need to refer to other communications between the parties to determine the parties' intent" Alday, 906 F.2d at 666; ". the SPD was the only document establishing the terms of the plan" Ozarks, at *7. That is not true in this case. The terms of the Trust Agreement are critical to determining the parties' intent and their rights and obligations. ERISA clearly requires the existence of not only an SPD, but a master plan document or documents from which information is drawn and summarized in creating the SPD. The Ninth Circuit held in Cline v. The Industrial Maintenance Engineering & Contracting Co., 200 F.3d 1223 (9th Cir. 2000) that the fact that the plan does not have a master plan document does not excuse it from the necessity of creating one when that document is requested by a plan participant.

> [i]f any of these documents do not exist at the time of a request, it is consistent with the aims of ERISA to impose a penalty on the plan administrator [because t]here is nothing keeping the administrator from preparing a mandatory document where none previously existed and it is his burden upon threat of penalty to do so.

Id, at 1234 (9th Cir. 2000), citing Jackson v. E.J. Brach Corp., 937 F.Supp. 735, 740, n. 6 (N.D.Ill. 1996).

Ozarks does identify information critical to the success of the plan's reimbursement argument in that

case that the Plan in this case has never produced. In Ozarks the plan fiduciary submitted evidence that the recovered funds would be deposited into that welfare benefit plan's trust account, would be available to pay medical expenses, and that the only use of the reimbursed funds was to fund the welfare benefit plan. Ozarks, at *16. That case supports Montanile's argument about the importance of the Plan providing to him and to this Court information that satisfies the requirements of ERISA's anti-inurement provision.

Ozarks also makes clear that the Plan's reimbursement claim against Montanile is valid only insofar as the Plan can target specifically identifiable funds in Montanile's possession that are attributable to the third party recovery. Ozarks, at *5-6. The Plan in this case could have identified, and placed an equitable lien against, specific funds that represented the money Montanile recovered from his personal injury claim if the Plan had acted in a timely way to secure its lien. But once those funds were disbursed after the Plan failed to act in a timely way to protect its interests, the Plan lost its ability to identify segregated, identifiable funds. With that loss goes the ability of the Plan to be reimbursed.

CONCLUSION

Under both the language of the plan documents and under the "appropriate equitable relief" language of 29 U.S.C. §1132(a)(3), the Plan's reimbursement claim must fail. It has not demonstrated that its SPD is the "Plan of Welfare Benefits" contemplated and referred to in the governing plan documents. It has also not shown that its reimbursement and subrogation language was formulated and adopted based on the

actuarial principles the Trust Agreement requires. It has never demonstrated that the disposition of the money it seeks from Montanile will not violate ERISA's anti-inurement provisions. Finally, it is self evident that to allow the Plan to obtain funds from Montanile after it failed and refused to provide Montanile assurance that its disposition of the funds would not violate ERISA would be going beyond the range of "appropriate equitable relief" that ERISA references as being the limits on the remedy to which the Plan is entitled. For all these reasons, the Plan's reimbursement claim must fail and this Court should grant Montanile's Motion for Summary Judgment.

DATED this 9th day of October, 2013.

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* * * [Certificate of Service omitted]* * *

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

CASE NO. 12-CV-80746-DLB

[Filed October 9, 2013]

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Plaintiff,

v.

ROBERT MONTANILE,

Defendant.

[ECF No. 41]

* * *

PLAINTIFF'S RESPONSE TO DEFENDANT'S ADDITIONAL STATEMENT OF UNDISPUTED MATERIAL FACTS

Plaintiff responds to the Defendant's Statement of Undisputed Material Facts as follows:

1. Plaintiff does not dispute the facts asserted in paragraphs 1, 2, 3, 4, 5, 7, 8, 9, 11, 12, and 14 of the Defendant's Statement of Additional Undisputed Material Facts.

2. With respect to Paragraphs 3 and 13, the Defendant's statement that he only received

"approximately $90,000" is not supported by the Disbursement of Settlement Sheet. Declaration of Robert Montanile, Exhibit A. The Disbursement of Settlement Sheet shows $108,607.07 allocated to the "Blue Cross Blue Shield/Healthcare Lien" Blue Cross Blue Shield of Illinois is the third party claims administrator of the National Elevator Industry Employee Benefit Plan. The Disbursement Sheet shows that $108,607.07 was originally withheld from the settlement proceeds to address the Plaintiff's reimbursement claim. In addition to these funds, an additional $88,809.28 was left for disbursement to Mr. Montanile. Either Mr. Montanile received significantly more than $90,000 from the settlement, or Mr. Montanile's counsel still holds $108,607.07 in trust on his behalf.

3. With respect to Paragraph 10, the Plaintiff disputes that Plaintiff's answer to Defendant's counsel's request did not demonstrate compliance with ERISA's anti-inurement terms.

* * *

No. 14-723

IN THE

Supreme Court of the United States

ROBERT MONTANILE,

Petitioner,

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Respondent.

On Writ of Certiorari to the
United States Court of Appeals
for the Eleventh Circuit

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July 6, 2015

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QUESTION PRESENTED

The petition in this case was granted to resolve an important question regarding the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA"). That question is:

Does a lawsuit by an ERISA fiduciary against a participant to recover an alleged overpayment by the plan seek "equitable relief" within the meaning of ERISA section 502(a)(3), 29 U.S.C. § 1132(a)(3), if the fiduciary has not identified a particular fund that is in the participant's possession and control at the time the fiduciary asserts its claim?

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OPINIONS BELOW

The opinion of the Eleventh Circuit in this case is unreported. Pet. App. 1-18. The district court's order granting summary judgment is also unreported. Pet. App. 19-45.

JURISDICTION

The judgment of the court of appeals was entered on November 25, 2014. Pet. App. 1. The petition for writ of certiorari was filed on December 16, 2014, and this Court granted the petition on March 30, 2015. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

Section 502 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132, as amended, provides in relevant part:

> (a) Persons empowered to bring a civil action
>
> A civil action may be brought—
>
> * * *
>
> (3) by a participant, beneficiary, or fiduciary
>
> (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or
>
> (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan; .

INTRODUCTION

In 2008, Petitioner Robert Montanile was severely and permanently injured by a drunk driver. Mr. Montanile recovered money in tort, and thereafter needed to use the proceeds for legal fees, daily living, and the care of his young daughter. After the money was spent, the fiduciaries of his health plan, the Board of Trustees of the National Elevator Industry Health Benefits Plan ("Respondent"), sued Mr. Montanile to recoup $121,044.02 it had paid for his medical expenses.

The lower courts entered and affirmed a $121,044.02 judgment of personal liability against Mr. Montanile to be satisfied out of any assets he possesses. At issue here is whether such a judgment is available under section 502(a)(3) of ERISA. The answer is no.

Section 502(a)(3) of ERISA authorizes "equitable relief." Under this Court's precedents, that phrase has a specific meaning: if the relief sought was "typically available" in pre-merger equity courts, it is available under ERISA. Otherwise, it is not. Historically, equitable relief was about the giving or enforcing of rights as to particular things—a parcel of land, a piece of personal property, a specific fund. Legal relief, in contrast, was about the recovery of money out of a defendant's general assets. Here, there is no thing against which Respondent is enforcing a right; the tort proceeds are gone. What Respondent instead seeks to impose is personal liability for a contractual obligation to pay money. That is not equitable relief. It is a claim for damages—the most classic form of legal relief.

The equitable remedy that Respondent requested in its complaint, an equitable lien by agreement, does not change the legal nature of Respondent's actual claim.

Unlike a true contract, an equitable lien by agreement is limited in effect: it only has power over a specific thing and its traceable products. It cannot reach other assets of the defendant. Yet that is precisely what Respondent asks this Court to sanction.

Respondent prevailed below by painting the strictures of equity as unpalatable. Such policy arguments, of course, should be directed at Congress. But Respondent's predictions of woe--that tort proceeds will be spent to stymie plans—are also wrong: Professional responsibility rules generally require attorneys to preserve funds on which a lien has been asserted. A preservation agreement provides further protection. Fiduciaries can seek an injunction to prevent dissipation. And, of course, proceeds converted to traceable products are always recoverable. Put simply, ERISA plans will get their money, unless they sleep on their rights.

At the same time, it is not mawkish to observe that these reimbursement cases are about monies paid to provide medical care for injured workers. Repose matters for all defendants, but particularly for them. Where a plan acts promptly and forthrightly, a participant can understand the claim and know with some certainty when it will be resolved. Respondent's rule, which permits secondary litigation years later, rewards delay and imposes emotional uncertainty on victims who should be spared that burden.

Reversal is warranted.

STATEMENT OF THE CASE

A. Factual Background

On December 1, 2008, Robert Montanile was seriously injured when a drunk driver ran a stop sign and struck his

automobile. Pet. App. 6; JA 23 (¶2); JA 75 (¶2). Mr. Montanile underwent lumbar spinal fusion surgery and other treatment to alleviate his pain and loss of function. Pet. App. 6; JA 75-76 (¶3). He requires ongoing medical care and continues to suffer pain and physical limitations. JA 75-76 (¶¶3-4).

Mr. Montanile was a participant in an ERISA-governed welfare plan administered by Respondent. Pet. App. 1-2; JA 23 (¶1).[1] As required by ERISA, "[t]he Plan paid Montanile's initial medical expenses of $121,044.02." Pet. App. 6; JA 23 (¶3).

Mr. Montanile hired a personal injury lawyer to sue the drunk driver. Pet. App. 6; JA 76 (¶5). After months of litigation, he obtained a $500,000 settlement. Pet. App. 6; JA 57-58 (¶5); JA 76 (¶5). Out of that settlement, Mr. Montanile paid his personal injury lawyers a $200,000 contingency fee and $63,788.48 in expenses. Pet. App. 6.

At that point, $236,211.52 of the settlement remained. But most of those funds were held in a client trust account pending the resolution of claims asserted by various third parties. JA 76 (¶5); JA 78-80 (Exh. A) (identifying $152,597.76 of asserted claims for which funds were being preserved). The largest asserted claim was that of

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[1] The Plan is a large multi-employer arrangement with approximately $1 billion in assets and more than 500 participating employers. *See* National Elevator Industry Health Benefit Plan, 2009 Form 5500 Annual Return/Report of Employee Benefit Plan (filed with the Dep't of Labor on Oct. 13, 2010), *available at* http://efast.dol.gov/portal/app/disseminate?execution=e1s1.

Respondent. JA 79 (indicating $108,607.07 for "Blue Cross Blue Shield/Health Care Lien").[2]

As a result of these third party claims, less than $90,000 was available for Mr. Montanile, "the custodial single parent for [his] 12-year old daughter," JA 77 (¶7) to use "in supporting [his] daughter and in maintaining [their] home." JA 76 (¶6). *See also* JA 76 (¶6) ("After payment of attorney fees and costs, satisfaction of liens, medical expenses, and other expenses, the amount remaining from the settlement as compensation for my injuries was approximately $90,000.").[3]

Indeed, it is beyond dispute that Mr. Montanile, seriously injured and permanently impaired, was not "made whole" by his tort settlement. JA 75-76 (¶3) ("I have been given a permanent partial impairment rating of 25%"); JA 76 (¶5) ("The amount recovered was not sufficient to compensate me for past and future medical expenses, past and future lost wages, losses associated with other out-of-pocket expenses, or compensation for my intangible losses.").

Concerned about his future ability to support himself and his daughter, Mr. Montanile retained ERISA attorney Brian S. King "to assist him in addressing [Respondent's] claim for reimbursement" for which

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[2] At the time, Mr. Montanile and his counsel believed the Plan had paid $108,607.07 of medical expenses. JA 78-80 (Exh. A). Mr. Montanile ultimately learned, however, that the Plan had paid $121,044.02. Compl. 2, July 11, 2012, ECF No. 1.

[3] *See also* JA 79-80 (Exh. A) (indicating that a total of $88,809.28 was made available to Mr. Montanile: $58,884.39 was advanced on April 29, 2011, $1,628.89 was advanced on July 1, 2011, and $28,296.00 were the "Final Funds Available to Client").

$108,607.07 was being preserved. JA 23 (¶6); JA 35 (¶3). Mr. King immediately endeavored "to verify the validity" and amount of Respondent's asserted claim. JA 35 (¶4).[4]

On June 6, 2011, Mr. King wrote to Respondent's counsel, Kejo Bryan-Carby. JA 68-74. Mr. King requested documents necessary to verify the validity and amount of the Plan's reimbursement claim, including "[a]ll documents under which the Plan was operated from January 1, 2008[] to the present." JA 70. And Mr. King specifically "reserve[d] the right to assert defenses based on the common fund doctrine and the made whole rule." JA 74.[5]

"Thereafter King and [Ms.] Bryan-Carby[] exchanged a series of letters in which King requested information and documents to verify the validity of the subrogation claim." JA 24 (¶7). "Eventually the Plan sent to King various documents including the National Elevator Bargaining Association Agreement [and] the Restated

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[4] *See also* JA 72 (requesting "a detailed statement of all monies paid on behalf of Mr. Montanile which you claim form any part of your claim for reimbursement, along with copies of all cancelled checks proving payment for those medical expenses.").

[5] Mr. King correctly observed that "*Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), left open the question of whether the made whole rule must be taken into account in evaluating what is 'appropriate equitable relief' authorized under 29 U.S.C. § 1132(a)(3)." JA 74 (citing *Sereboff*, 547 U.S. at 368, n.2). His position would ultimately be rejected by this Court, but not until April 16, 2013, in *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013) (holding that plan terms can override equitable doctrines).

Agreement and Declaration of Trust " as well as the operative summary plan description ("SPD"). JA 24 (¶9).

After carefully reviewing the documents provided by Ms. Bryan-Carby, Mr. King reached the conclusion that the Plan did not include an enforceable subrogation or reimbursement provision because the language relied upon by Respondent was found only in the SPD. JA 66-67 (¶¶1-3). *See also* Brief for the Appellant at 7-11, *Board of Trustees of the Natl. Elev. Industry Health Benefit Plan v. Montanile*, 593 F. App'x 903 (11th Cir. 2014) (No. 14-11678) 2014 WL 2556236, at *7 (discussing each of the documents provided to Mr. King by Ms. Bryan-Carby); *id.* at 15-28 (explaining and defending the precise conclusion reached by Mr. King in late 2011—*i.e.*, that a reimbursement provision found *only* in the SPD of an ERISA welfare plan is not enforceable in light of *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011)).[6]

On November 30, 2011, Mr. King wrote Respondent's counsel and "informed her that he did not believe the governing plan documents provided the Plan with any subrogation rights and asked that she produce a governing plan document containing language that entitled the Plan to assert its subrogation claim." JA 24 (¶10). In that letter, Mr. King "indicated that if the Plan

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[6] Several courts have reached the same conclusion. *See, e.g.*, *Mull v. Motion Picture Industry Health Plan*, 51 F.Supp.3d 910, 918-25 (C.D. Cal. Sept. 30, 2014) (concluding, based on post-*Amara* Ninth Circuit authority, that "[Participants and Beneficiaries] Are Entitled to Judgment Because No Plan Document Contains a Third-Party Recovery Reimbursement Provision, Only the Summary Plan Description ('SPD') Does"). The courts in this case, however, disagreed. *See* Pet. App. 12-17 (court of appeals rejecting the position of Mr. Montanile on the "plan document" question); Pet. App. 25-30 (district court rejecting same).

did not respond by December 14, 2011, he intended to disburse the [disputed] settlement funds to Montanile." JA 24 (¶11).

On December 12, 2011, Respondent's counsel wrote back to Mr. King "maintain[ing the] position that the SPD, which contains subrogation language for the Plan, was the governing plan document." JA 24 (¶12). The Plan also made a settlement offer. JA 24-25 (¶12).

On December 13, 2011, Mr. King responded by letter "reiterat[ing] Montanile's position that the Plan was not entitled to any subrogation recovery because the SPD language was not based on any governing plan document language " JA 25 (¶13). He made a settlement counteroffer. JA 25 (¶13). "The Plan rejected Montanile's counteroffer and provided a final counteroffer of its own stat[ing] that failure to accept its final offer would result in litigation." JA 25 (¶14); JA 35 (¶11).

On January 6, 2012, "King wrote and requested that if the Plan intended to litigate the matter, it do so within 14 days. He stated that he would release the funds to Montanile if he had not been served with the Plan's Complaint by January 20, 2012." JA 25 (¶15); JA 35 (¶12). "The Plan did not respond to the [January 6, 2012] letter and King's office disbursed the [approximately $100,000 in disputed settlement] funds to Montanile on February 2, 2012." JA 25 (¶16); JA 35 (¶13).

In the six months that followed, Respondent did not contact Mr. King or take any action against Mr. Montanile. *See* JA 25 (¶¶15-17); JA 35 (¶¶12-14). *See also* Pet. App. 34 (district court noting that "[t]here is no dispute that

Plaintiff filed suit against Defendant six months after the parties exchanged final settlement offers").

B. Procedural History

On July 11, 2012, Respondent sued Mr. Montanile under 29 U.S.C. § 1132(a)(3) seeking reimbursement of the benefits that the Plan paid to his medical providers. Pet. App. 7. Section 502(a)(3) of ERISA authorizes a fiduciary to seek "appropriate equitable relief" to "enforce . . . the terms of the plan." 29 U.S.C. § 1132(a)(3). Respondent did not seek any provisional relief to preserve the settlement money.

Relying on *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), Respondent sought reimbursement in the form of an equitable lien by agreement to "enforce the terms of the [National Elevator Plan]." Brief for the Appellant at 12, *Montanile*, 593 F. App'x 903 (No. 14-11678). But by the time the lawsuit was filed, Mr. Montanile was no longer "in actual or constructive possession of any but a small portion of the proceeds realized from the settlement of his claims." JA 57 (¶14).

After exchanging Rule 26(a) disclosures, the parties cross-moved for summary judgment. Brief for the Appellant at 12-13, *Montanile*, 593 F. App'x 903 (No. 14-11678). Mr. Montanile argued that the governing plan documents did not give the Plan any reimbursement rights. JA 27-30. As Mr. Montanile explained:

> The Bargaining Association Agreement and the Restated Agreement and Declaration of Trust are the only documents that were negotiated between the employers and the employee union. Those documents establish the rights and obligations between the

> parties. They are silent about the subrogation and reimbursement rights for the Plan. [B]y definition, the SPD is a summary of other governing plan documents. The Plan may not create subrogation and reimbursement rights out of thin air, unilaterally place them in the SPD, and insist that this Court enforce those rights.

JA 27-28. Mr. Montanile also sought an award of attorneys' fees against Respondent on the grounds that it acted culpably in delaying suit for months after the money had been disbursed. JA 30-33.

In opposing Respondent's motion for summary judgment, Mr. Montanile renewed his argument that the SPD did not create a valid reimbursement right. JA 59-63. But he *also* argued that the reimbursement it sought did not constitute "appropriate equitable relief" because the funds on which it wished to assert an equitable lien by agreement had been dissipated. Pet. App. 8. In his view, the lawsuit was particularly unfair because Respondent had "failed to act responsibly and promptly in protecting the reimbursement interests of the Plan." JA 64-65. Not only did Respondent wait six months before filing suit, but it did *nothing* to prevent distribution of the funds to Mr. Montanile or to preserve them after disbursement. JA 65.

Relying on affidavit testimony attached by Respondent to its reply brief, the district court held that the reimbursement provision of the SPD was enforceable because it did not conflict with the Declaration of Trust and the Bargaining Association Agreement, which were silent on reimbursement. Pet. App. 26-28. And it distinguished *Amara* on the grounds that the SPD "in this

case did not inaccurately describe plan information or add new inconsistent terms." Pet. App. 29.

With respect to whether Respondent sought "appropriate equitable relief" in demanding a judgment against Mr. Montanile's general assets, the district court acknowledged that "*Sereboff* did not address the issue of a beneficiary's dissipation of assets because the funds there were placed in a separate account throughout the duration of the case" and that the "Eleventh Circuit has similarly not had occasion to address the issue of dissipation." Pet. App. 40. Nevertheless, believing that it was following "the overwhelming majority of circuit courts," the district court granted summary judgment to Respondent. Pet. App. 40.

Mr. Montanile timely appealed. Pet. App. 9. He argued that the Reimbursement Provision of the SPD is not an enforceable term of the Plan because a single document cannot qualify as both the SPD required by 29 U.S.C. § 1022 and the "written instrument" required by 29 U.S.C. § 1102. Brief for the Appellant at 17-21, *Montanile*, 593 F. App'x 903 (No. 14-11678). And even if a single document could theoretically serve both functions, the SPD at issue here did not as a factual matter. *Id.* at 21-28.

Mr. Montanile also argued that 29 U.S.C. § 1132(a)(3) authorizes equitable relief only to the extent available at common law. *Id.* at 15. At common law, an equitable lien by agreement could be enforced against specific property within the current possession and control of the debtor but not against his general assets. *Id.* Because Mr. Montanile's settlement fund was almost entirely dissipated in good faith prior to the initiation of this lawsuit, the magistrate judge erred in granting summary

judgment to Respondent and imposing personal liability on Mr. Montanile. *Id.*

After the parties had fully briefed Mr. Montanile's appeal, a divided three-judge panel of the Eleventh Circuit in *AirTran Airways, Inc. v. Elem.* Pet. App. 46-76, decided the question presented and rejected the position advocated by Mr. Montanile and endorsed by the United States. Pet. App. 53-54. Judge Martin dissented. *See* Pet. App. 65 (Martin, J., dissenting) ("Supreme Court precedent makes clear that a plaintiff proceeding in equity to recover funds from a defendant must, at a minimum, show that those funds are presently in the defendant's possession.").

Shortly thereafter, a different Eleventh Circuit panel heard oral argument on Mr. Montanile's appeal. Less than one week after hearing oral argument, that panel rejected Mr. Montanile's arguments and affirmed the district court. Pet. App. 2. Citing circuit precedent from 1990, the panel concluded that a single document can serve as both the written instrument and the SPD, and that the SPD in this case filled both roles. Pet. App. 12, 17.[7]

The panel acknowledged that its holding was in tension with *Amara*. Pet. App. 14 ("[D]icta from the Supreme Court is not something to be lightly cast aside. "). Yet it distinguished *Amara* on the narrow grounds that in that case, this Court "had no occasion to

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[7] The panel's factual determination rested on its unwillingness to hold that the multibillion dollar Plan had violated ERISA by failing to enact a written instrument at all: "[I]f the enforceable terms of the Plan were limited to those found in the Trust Agreement, there would be *no* governing document that specifies Plan participants' rights or obligations regarding benefits. We refuse to embrace such an outcome." Pet. App. 17.

consider whether the terms of a summary plan description are enforceable where it is the only document that 'specif[ies] the basis on which payments are made to and from the plan, as required by § 1102(b)." Pet. App. 15.

The panel also noted that Mr. Montanile's equitable relief argument "is now foreclosed by [the] recent holding in [*AirTran*]." Pet. App. 11. It therefore concluded that "the Board can impose an equitable lien on Montanile's settlement even if dissipated . . ." Pet. App. 11.

On December 16, 2014, Mr. Montanile timely petitioned this Court for a writ of certiorari. *Board of Trustees of the National Elevator Industry Health Benefit Plan v. Montanile*, 593 F. App'x 903 (11th Cir. 2014), *petition for cert. filed*, 2014 WL 7242807 (U.S. Dec. 16, 2014) (No. 14-723). The petition presented only the "equitable relief" question.[8]

SUMMARY OF ARGUMENT

If *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002) remains good law, Respondent's claim must fail. As this Court wrote then:

> Here, the funds to which [the Plan] claim[s] an entitlement under the Plan's reimbursement provision—the proceeds from the settlement of [the beneficiaries'] tort action—are not in [the beneficiaries'] possession. The basis for [the Plan's] claim is <u>not</u> that [the beneficiaries] <u>hold</u> particular funds that, in good conscience,

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[8] Although the "plan document" question itself has confounded lower courts (*supra* 7 n.6), Petitioner elected to submit a single-question petition in order to maximize the likelihood of further review.

> belong to [the Plan], but that [the Plan is] contractually entitled to *some* funds for benefits that they conferred. The kind of restitution that [the Plan] seek[s], therefore, is not equitable—the imposition of a constructive trust or equitable lien on particular property—but legal—the imposition of personal liability for the benefits that they conferred upon [the beneficiaries].

Great-West, 534 U.S. at 214 (underlining added) (italics in original). Because seeking "to obtain a judgment imposing a merely personal liability upon the defendant to pay a sum of money" is legal relief, this Court held that the fiduciary's claims in *Great-West* were not cognizable under section 1132(a)(3) of ERISA. *Id.* at 213, 218. Nothing about this case requires, or permits, a different result.

Like the fiduciary in *Great-West*, Respondent wants to enforce a contractual reimbursement provision in its ERISA plan but *not* by equitably attaching specific funds in the possession of a plan participant. Like the fiduciary in *Great-West*, what Respondent seeks is a personal money judgment. And like the fiduciary in *Great-West*, Respondent is not entitled to such a remedy.

As such, Respondent's litigation strategy has been two-fold: (i) to assert that the "equitable lien by agreement" remedy endorsed by this Court in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), somehow trumps the core teaching of *Great-West* and (ii) to offer policy arguments urging de facto abrogation of this Court's longstanding, but admittedly controversial,

interpretation of 29 U.S.C. § 1132(a)(3).[9] That strategy should not succeed.

In *Sereboff*, this Court recognized that a fiduciary may seek an equitable lien by agreement pursuant to 29 U.S.C. § 1132(a)(3). But *Sereboff* said nothing about the dispositive issue here: is such a lien enforceable when the particular funds to which the lien attached are not in the possession or control of the defendant? The answer is no. Indeed, it is axiomatic that liens follow specific things, not specific persons. As the First Restatement on Restitution put it: "An equitable lien can be established and enforced only if there is some property which is subject to the lien. Where, however, the property subject to the equitable lien can no longer be traced, the equitable lien cannot be enforced." Restatement (First) of Restitution § 161 cmt. e, at 652 (1937).

Virtually conceding that point, Respondent appears to offer a newly minted rationale in support of the decision below: the "deficiency decree." Brief of Respondent at 19-20, *Board of Trustees of the Natl. Elev. Industry Health Benefit Plan v. Montanile*, No. 14-723 (filed Feb. 19, 2015) ("Orange Br."). But this new position cannot justify affirmance. It is well-settled that the deficiency judgment is a legal remedy that might be awarded by equity courts in particular circumstances. That a pre-merger court of equity could and did award such a remedy does not make

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[9] *See, e.g.*, John H. Langbein, *What ERISA Means By 'Equitable': The Supreme Court's Trail of Error in* Russell, Mertens, *and* Great-West, 103 Colum. L. Rev. 1317, 1361 (2003) ("It was Justice Scalia, or rather, the five-member Supreme Court majority assembled for his opinions, and not Congress, which gave the term [appropriate equitable relief] the unnatural and dysfunctional meaning propounded in *Mertens* and *Great-West*.").

that remedy equitable—any more than a jockey driving a car makes it a horse. Indeed, this Court expressly rejected the very premise of Respondent's argument over twenty years ago in *Mertens v. Hewitt Associates*, 508 U.S. 248, 256 (1993) (holding that "equitable relief" does *not* mean "whatever relief a court of equity is empowered to provide in the particular case at issue."). In any event, Respondent's new position would—at a minimum—necessitate reversal and remand to litigate its applicability on the merits.

With all due respect, Petitioner suggests that the rejection of his position is not the result of analysis of pre-merger equity practice; instead, it is the result of the lower courts' acceptance of policy arguments advanced by fiduciaries such as Respondent. But, as this Court has repeatedly noted, those arguments should be directed at Congress. And, in any event, they are wrong. The rule advanced by Respondent is unnecessary, overbroad, and strikes a poor balance between competing goals of ERISA. It is neither equitable nor sensible.

ARGUMENT

I. As *Great-West* Held: "Personal Liability . for a Contractual Obligation to Pay Money" Is Not "Equitable Relief" Under 29 U.S.C. § 1132(a)(3).

Two decades ago, this Court first interpreted the phrase "equitable relief" in 29 U.S.C. § 1132(a)(3). *See Mertens v. Hewitt Associates*, 508 U.S. 248 (1993). The Court held that the plaintiffs in that case did not seek "equitable relief" because the objective of their lawsuit was to recover compensatory damages—not "a remedy traditionally viewed as 'equitable.'" *Id.* at 255.

In deciding *Mertens*, this Court rejected the position advanced by the United States that "equitable relief" meant "whatever relief a court of equity is empowered to provide in the particular case at issue," even while acknowledging that the phrase in isolation could bear that meaning. *Id.* at 256. Rather, the Court held that by choosing the phrase "equitable relief," Congress intended to create a private right of action that allowed only the recovery of "those categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Id.* (emphasis in original).

Although *Mertens* established the "typically available in equity" standard, it applied that standard in a particular setting: a lawsuit brought by ERISA plan participants and beneficiaries *against a non-fiduciary*. *Id.* at 250-51. It did not address what remedies would qualify as typically available in equity when sought by ERISA plan participants and beneficiaries in litigation *against a fiduciary*.[10] And it also did not address what remedies would qualify as typically available in equity when sought *by a fiduciary* in litigation against a plan participant. That question eventually reached the Court in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002).

In *Great-West*, this Court applied the *Mertens* standard and squarely held that the phrase "equitable relief" in 29 U.S.C. § 1132(a)(3) was not intended by Congress to authorize ERISA fiduciaries to seek judicial

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[10] That question eventually reached the Court in *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011), which held that, in a suit by a beneficiary against a fiduciary, section 1132(a)(3) authorized reformation, estoppel, and surcharge. *Id.* at 1879-80.

imposition of personal liability on plan participants for breach of contract. To this day, *Great-West*'s core holding remains good law. And for good reason. *Great-West*'s recognition of the limited judicial remedies available to fiduciaries in litigation against plan participants is based on an appreciation of the "balance between . competing goals that the text adopted by Congress has struck." *Mertens*, 508 U.S. at 263.

A. The text of 29 U.S.C. § 1132(a) does not authorize fiduciaries to seek imposition of personal liability on plan participants.

29 U.S.C. § 1132(a) contains ERISA's exclusive remedial provisions. When ERISA was enacted, there were six. *See* 29 U.S.C. §§ 1132(a)(1)-(6) (1974). Today, there are ten. *See* 29 U.S.C. §§ 1132(a)(1)-(10) (2012) (amended to include paragraphs (7) and (8) by Pub. L. No. 103-66, § 4301, 107 Stat. 376 (1993); amended to include paragraph (9) by Pub. L. No. 103-401, § 2, 108 Stat. 4172 (1994); amended to include paragraph (10) by Pub. L. No. 109-280, §§ 202(c)-221(c), 120 Stat. 884 (2009)).

Five of these provisions create a cause of action for plan participants and beneficiaries. *See* 29 U.S.C. §§ 1132(a)(1), (2), (3), (4), and (9). Three of these provisions create a cause of action for plan fiduciaries. *See* 29 U.S.C. §§ 1132(a)(2), (3), and (9). Six of these provisions create a cause of action for the Secretary of Labor. *See* 29 U.S.C. §§ 1132(a)(2), (4), (5), (6), (8), and (9). One of these provisions creates a cause of action for States. *See* 29 U.S.C. § 1132(a)(7). Two of these provisions create a cause of action for employers. *See* 29 U.S.C. §§ 1132(a)(8) and (10). And exactly *none* authorizes a plan fiduciary to seek imposition of personal liability on a plan participant for a contractual obligation to pay money.

Section 502(a)(1) of ERISA imposes liability for a contractual obligation to pay money, but it does not authorize litigation *by a fiduciary*. *See* 29 U.S.C. § 1132(a)(1)(B) (authorizing a participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."). Indeed, as this Court expressly noted in *Great-West*:

> Congress authorized "a participant or beneficiary" to bring a civil action "to enforce his rights under the terms of the plan . . " 29 U.S.C. § 1132(a)(1)(B) (1994 ed.). But Congress did not extend the same authorization to fiduciaries.

Great-West, 534 U.S. at 221.

Unlike section 502(a)(1), section 502(a)(2) of ERISA does authorize litigation by a fiduciary. *See* 29 U.S.C. § 1132(a)(2) (authorizing a civil action "by the Secretary, or by a participant, beneficiary *or fiduciary* for appropriate relief under section 1109 of this title") (emphasis added). But it does not authorize litigation *against a participant or beneficiary*—only against another fiduciary. And it imposes liability for the breach of statutory (not contractual) duties. *See* 29 U.S.C. § 1109(a) (A "fiduciary who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach . . .").

Section 502(a)(3) of ERISA is the only provision in the statute that permits a fiduciary to sue a plan participant for breach of contract. *See* 29 U.S.C. § 1132(a)(3)

(authorizing litigation by, *inter alia*, a fiduciary to obtain "appropriate equitable relief to enforce the terms of the plan").[11] But this Court made clear in *Great-West* that section 1132(a)(3) does *not* authorize a fiduciary to seek judicial imposition of a personal money judgment:

> Here, petitioners seek, in essence, to impose personal liability on respondents for a contractual obligation to pay money—relief that was not typically available in equity. A claim for money due and owing under a contract is quintessentially an action at law. Almost invariably suits seeking (whether by judgment, injunction, or declaration) to compel the defendant to pay a sum of money to the plaintiff are suits for money damages, as that phrase has traditionally been applied, since they seek no more than compensation for loss resulting from the defendant's breach of legal duty. And [m]oney damages are, of course, the classic form of *legal* relief.

Great-West, 534 U.S. at 210 (internal quotation marks and citations omitted) (alteration in original).

That core holding of *Great-West* reflects this Court's recognition of the fact that Congress knew how to authorize fiduciaries to seek money damages for breach of contract when it so desired. *See, e.g.*, 29 U.S.C. § 1451(a)-(b) ("A plan fiduciary . . . may bring an action for

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[11] The other provisions of ERISA that create a private right of action for fiduciary plaintiffs do not authorize litigation against plan participants or beneficiaries. *See* 29 U.S.C. § 1132(a)(9) (permitting litigation against an annuity provider); *id.* § 1451(a)-(b) (permitting litigation against an employer for withdrawal liability).

appropriate legal or equitable relief, or both" against an employer for withdrawal liability) (emphasis added). *See also Mertens*, 508 U.S. at 258 (expressly noting "the distinction Congress drew between 'equitable' and 'legal' relief in the very same section of ERISA ") (citing 29 U.S.C. § 1132(g)(2)(E)).[12]

B. Limiting the scope of relief available to fiduciaries in litigation against participants was a sensible balance struck by Congress.

Overpayments in cases such as this one, as well as in other settings like disability and pension, could result in the depletion of plan assets. That said, it is hard to believe that plan fiduciaries require the ability to seek judicial imposition of personal liability on participants in order to effectively protect plan assets.

Pension and disability cases will constitute the mine run of overpayment disputes, and in such cases there is clearly no need for the fiduciary to seek money damages against the participant. Fiduciaries regularly offset alleged overpayments against continued benefits. *See, e.g., Northcutt v. Gen. Motors Hourly-Rate Employees Pension Plan*, 467 F.3d 1031 (7th Cir. 2006) (ERISA plan suspended future benefit payments when participants refused to repay the plan after receiving retroactive social

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[12] Section 502(g) of ERISA deals with "awards in actions involving delinquent contributions." 29 U.S.C. § 1132(g). In pertinent part, it provides that "[i]n any [successful] action under this subchapter by a fiduciary . . . to enforce section 1145 of this title . . . , the court shall award . . . , (A) the unpaid contributions, (B) interest on the unpaid contributions, (C) liquidated damages , (D) reasonable attorney's fees . . . , and (E) such other *legal or equitable relief* as the court deems appropriate." 29 U.S.C. § 1132(g)(2) (emphasis added).

security awards); *White v. Coca-Cola Co.*, 542 F.3d 848 (11th Cir. 2008) (ERISA plan reduced future benefits to recoup overpayments resulting from participants' receipt of social security disability benefits). And where that is not possible or desirable, fiduciaries can seek to recover the specific overpayment or its traceable product which remains in the hands of the participant or is in the hands of a third person who does not qualify as a bona fide purchaser for value. *See infra* 29-35 (explaining the proper enforcement of an equitable lien).[13] This will cover most tort recovery reimbursement cases as well.

On the other hand, permitting plan fiduciaries to seek judicial imposition of personal liability against participants risks converting participants into insurers of plan negligence. *See, e.g.*, Ellen Schultz, *'Overpaid' Pensions Being Seized*, Wall St. J. (Aug. 13, 2010), *available at* http://www.wsj.com/articles/SB10001424052748703723504575425421188456544. Moreover, as evidenced by this case, it incentivizes unnecessary delay in the exercise of plan reimbursement rights. *See supra* 6-9 (describing Respondent's conduct).

In sum, the decision to limit the relief available to fiduciaries in litigation against participants is sensible. And this Court was correct to recognize the "balance between competing goals that the text adopted by Congress has struck." *Mertens*, 508 U.S. at 263.

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[13] If (as in this case) there is a heated disagreement over the legitimacy and/or size of the plan's reimbursement claim, the fiduciary can–and should–seek an injunction to preserve the funds in dispute. That is precisely what occurred, for example, in both *Sereboff*, 547 U.S. at 360, and *McCutchen*, 133 S. Ct. at 1543.

II. The Decision Below Must Be Reversed and Remanded Because It Affirmed a Judgment of Personal Liability By Incorrectly Calling It an Equitable Lien.

At bottom, this case is no different from *Great-West*. Like the fiduciary in *Great-West*, Respondent wants to enforce a contractual reimbursement provision in its ERISA plan but *not* by equitably attaching specific funds in the possession of a plan participant. Like the fiduciary in *Great-West*, what Respondent seeks is a personal money judgment. And like the fiduciary in *Great-West*, Respondent is not entitled to such a remedy. In holding otherwise, the decision below violated the core teaching of *Great-West* based upon a fundamental misunderstanding of this Court's holding in *Sereboff* and the well-settled historical rules governing equitable liens.

A. *Great-West* made clear that a personal money judgment is not equitable relief *even if* it arises from a dissipated but identifiable fund.

As explained above (*see supra* 16-21), *Great-West* established the core principle that 29 U.S.C. § 1132(a)(3) does not authorize the imposition of personal liability upon a participant for breach of contract, because such a recovery from the participant's general assets does not constitute equitable relief. The facts of *Great-West* are striking similar to those at issue in this case:

Janette Knudson was severely injured in a car accident, and a portion of her medical expenses were paid by Great-West Life & Annuity Ins. Co. ("Great West") because Janette was the beneficiary of a welfare benefit plan. *Great-West*, 534 U.S. at 207. A reimbursement provision in the plan obligated Janette to reimburse the

plan from any settlement with a third-party tortfeasor. *Id.* at 207.

Janette and her husband did obtain a $650,000.00 tort settlement, but they did not fully reimburse the plan for the $411,157.11 that the plan (and Great-West as stop-loss insurer) had paid on Janette's behalf. Instead, the tort settlement was allocated between creditors and a Special Needs Trust. Over half of the settlement was spent to pay creditors ($373,426 to the attorneys for their fees and costs and $5,000 to Medi-Cal), a small amount ($13,828.70) was segregated to reimburse Great-West, and $256,745.30 was allocated to a Special Needs Trust. *Id.* at 207-08.[14]

Great-West and the ERISA plan sued the Knudsons under 29 U.S.C. § 1132(a)(3) to recover the $411,157.11 in medical expenses that had been paid on Janette's behalf. *Id.* at 208. This Court affirmed the grant of summary judgment in favor of the Knudsons. *Id.* at 221.

The Court recognized that plaintiffs can obtain restitution in equity by seeking an equitable lien or constructive trust, *id.* at 213, but the Court next quoted a critical governing principle:

> [W]here "the property [sought to be recovered] or its proceeds have been dissipated so that no product remains, [the plaintiff's] claim is only that of a general creditor," and the plaintiff "cannot enforce a constructive trust of or an equitable lien upon other property of the [defendant]." Restatement of Restitution, *supra*, § 215, Comment *a*, at 867. Thus, for restitution to

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[14] The Court's opinion does not appear to account for the remaining $1,000. Presumably it was also dissipated.

> lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession.

Great-West, 534 U.S. at 213-14.

The Court then proceeded to point out that: "the funds to which petitioners claim an entitlement under the Plan's reimbursement provision—the proceeds from the settlement of [the Knudsons'] tort action—are not in [the Knudsons'] possession." *Id.* at 214. Rather, the facts showed that the settlement proceeds had been partially dissipated (*e.g.*, used to pay the Knudson's non-ERISA creditors such as Medi-Cal) and partially preserved, but in a Special Needs Trust that placed the money beyond the Knudsons' control. *Id.* at 214.[15]

Because the plaintiffs' reimbursement claim was "not that [the Knudsons] hold particular funds that, in good conscience, belong to petitioners, but that petitioners are contractually entitled to *some* funds for benefits that they conferred[,]" the Court held that "[t]he kind of restitution

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[15] Respondent glibly asserts that "the settlement funds in *Great-West* were *never* attached to anything held by the beneficiary," Orange Br. 18, because "the 'state court's order provided that the defendants would pay the settlement amount allocated to the Special Needs Trust directly to the trust . . . .'" *Id.* Even if that were true with regard to the *preserved* funds (*i.e.*, assets of the Special Needs Trust), it is not true with regard to the *dissipated* funds (*e.g.*, monies used by the Knudsons' attorney to pay, for example, Medi-Cal).

that petitioners [sought]" was not equitable. *Id.* at 214 (emphasis in original).

B. The decision below violated the core teaching of *Great-West* based on a misreading of *Sereboff*.

In this case, the court of appeals adopted a position that directly conflicts with the core teaching of *Great-West* based on a fundamental misunderstanding of *Sereboff v. Mid-Atlantic Medical Services*, 547 U.S. 356 (2006). *See, e.g.*, Brief for the United States as Amicus Curiae at 9-15, *Thurber v. Aetna Life Ins. Co.*, 134 S. Ct. 2723 (U.S. May 6, 2014) (No. 13-130), 2014 WL 1783200 (explaining the lower courts' misreading of *Great-West* and *Sereboff*). Because the decision below turns on the court's misreading of *Sereboff*, a brief discussion of that case—and the Court's opinion—is warranted:

In *Sereboff*, this Court permitted a plan fiduciary to enforce a reimbursement provision by seeking a judgment against a specifically identifiable fund that was—unlike in *Great-West*—in the beneficiaries' possession and control. *Sereboff*, 547 U.S. 356. As in *Great-West*, the ERISA participant and beneficiary (the Sereboffs) were injured in a car accident and some of their medical expenses were paid by an employer-sponsored health insurance plan. *Id.* at 360. After the Sereboffs commenced a tort suit against third parties, Mid Atlantic promptly asserted its right to be reimbursed out of any potential recovery, and it continued to assert its reimbursement right during the pendency of the Sereboffs' tort suit. *Id.* at 360.

When the Sereboffs settled for $750,000, Mid Atlantic quickly filed a suit under 29 U.S.C. § 1132(a)(3), seeking to recover the $75,000 in medical expenses that it had paid. Mid Atlantic sought a temporary restraining order

and preliminary injunction to preserve a portion of the tort recovery. The parties ultimately entered into a court-approved stipulation whereby the Sereboffs would preserve $75,000 "of the settlement funds." *Id.* at 360. This fact was critical to the Court's holding that Mid Atlantic's lawsuit was authorized by ERISA. Pointing to the portion of the settlement fund that was "set aside and 'preserved [in the Sereboffs'] investment accounts,'" the Court held that "the nature of the recovery" sought by Mid Atlantic was equitable because "*[u]nlike Great-West*, Mid Atlantic did not simply seek 'to impose personal liability . . . for a contractual obligation to pay money.'" *Id.* at 362-63 (emphasis added).

The Court next concluded that "case law from the days of the divided bench confirms that [the basis for] Mid Atlantic's claim is equitable." *Id.* at 363. Citing *Barnes v. Alexander*, 232 U.S. 117 (1914), the Court explained that the plan's reimbursement provision "specifically identified a particular fund, distinct from the Sereboffs' general assets and a particular share of that fund to which Mid Atlantic was entitled," so Mid Atlantic "could rely on a 'familiar rule of equity' . . [which] allowed [Mid Atlantic] to 'follow' a portion of the recovery 'into the Sereboffs' hands' 'as soon as the settlement fund was identified,' and impose on that portion a constructive trust or equitable lien." *Sereboff*, 547 U.S. at 364 (citing and quoting *Barnes v. Alexander*, 232 U.S. 117, 121, 123 (1914)) (internal quotation marks and brackets omitted).

The Court clarified that Mid Atlantic was seeking "an equitable lien 'by agreement.'" *Sereboff*, 547 U.S. at 364-65. This meant, according to the Court, that Mid Atlantic did not need to "satisfy the 'strict tracing rules' for 'equitable restitution.'" *Id.* at 365 (quoting Reply Brief for

Petitioners at 8, *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006) (No. 05-260), 2006 WL 165865, at *8 ("*Sereboff* Reply")).

This language has been widely misinterpreted and misunderstood. *See, e.g.*, Orange Br. 16-17 (asserting that *Sereboff* rejected the requirement that an equitable lien can be enforced only against property that is in the possession of the defendant at the time of enforcement). The tracing that the Court was referring to was "the tracing requirement of the sort asserted *by the Sereboffs*." *Sereboff*, 547 U.S. at 365 (emphasis added). The Sereboffs had argued that an equitable lien was unavailable because the plan could not specifically identify an asset that the Sereboffs had misappropriated from the plan; rather, the plan sought an equitable lien on an asset that was recovered from a third party. *Sereboff* Reply at 9-10 (arguing that Mid Atlantic could not recover because the settlement fund in the Sereboffs' possession could not be traced back to Mid Atlantic); *see also id.* at 8 (equitable liens had "strict tracing rules").

To be sure: the Court rejected the need to trace an asset from the hands of the plaintiff to the hands of the defendant.[16] But, in so doing, the Court unquestionably did *not* overrule the core teaching of *Great-West*—*i.e.*, that "where 'the property [sought to be recovered] or its

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[16] It acknowledged that equitable liens were "often" imposed when "an asset belonging to the plaintiff had been improperly acquired by the defendant and exchanged by him for other property." *Sereboff*, 547 U.S. at 364. But the Court explained that an equitable lien *by agreement* was different: it was available even though "[t]he plaintiffs could not identify an asset they originally possessed, which was improperly acquired and converted into property the defendant held." *Id.* at 365 (discussing *Barnes*, 232 U.S. 117).

proceeds have been dissipated so that no product remains, [the plaintiff's] claim is only that of a general creditor,' and the plaintiff 'cannot enforce a constructive trust of or an equitable lien upon other property of the [defendant].'" *Great-West*, 534 U.S. at 213-14 (quoting Restatement of Restitution & Unjust Enrichment § 215 cmt. a, at 867 (1936)).

C. An equitable lien, unlike a personal money judgment, is only enforceable against specific property or its traceable proceeds.

Sereboff cannot possibly have held what Respondent claims it did because, as previously explained by the United States, such a holding is irreconcilable with black-letter principles that this Court has repeatedly held must undergird any claim for equitable relief under ERISA. *See, e.g.*, Brief for the United States as Amicus Curiae at 12, *Thurber*, 134 S. Ct. 2723 (No. 13-130) (making that point). As explained next, it is beyond any serious dispute that an equitable lien can only be enforced against specifically identified property or its traceable product.

1. An equitable lien by agreement cannot exist in the absence of an agreement that the plaintiff is entitled to a specifically identifiable fund. An equitable lien by agreement "must deal with some particular property, either by identifying it, or by so describing it that it can be identified, and must indicate with sufficient clearness and intent that the property so described, or rendered capable of identification, is to be held, given, or transferred as security for the obligation." 4 Spencer W. Symons, *Pomeroy's Treatise on Equity Jurisprudence as Administered in the United States of America* § 1235, at 698 (5th ed. 1941) ("4 Pomeroy"); *see also* Christopher G. Tiedeman, *A Treatise on Equity Jurisprudence* § 385, at

463-64, § 387, at 465 (St. Louis, F.H. Thomas Law Book Co. 1893) ("Tiedeman"). An equitable lien can exist upon property to be acquired in the future, and it will be "enforced in the same manner and against the same parties as a lien upon specific things existing and owned by the contracting party at the date of the contract." 4 Pomeroy § 1236, at 700; *see also* Tiedeman § 386, at 464.

In *Sereboff*, "the 'Acts of Third Parties' provision in the Sereboffs' plan specifically identified a particular fund, distinct from the Sereboffs' general assets—'[a]ll recoveries from a third party (whether by lawsuit, settlement, or otherwise)'—and a particular share of that fund to which Mid Atlantic was entitled " 547 U.S. at 364. And *Barnes v. Alexander*, 232 U.S. 117 (1914), on which the Court relied heavily, underscores this point.

In *Barnes*, two attorneys (Street and Alexander) claimed an equitable lien upon a settlement fund that was in the hands of the widow of their co-counsel (Barnes). *Barnes*, 232 U.S. at 119. Street and Alexander based their claim on Barnes' promise to pay them one-fourth of his contingent fee, *id.* at 119, and a primary focus of the Court's attention was whether that agreement was merely "a personal promise that gave [Street and Alexander] no specific claim against the [settlement] fund." *Id.* at 120. The Court explained that Barnes' agreement with Street and Alexander was "aimed only at the fund. Barnes gave no general promise of reward; he did not even give a promise qualified and measured by success to pay anything out of his own property, referring to the fund simply as the means that would enable him to do it." *Id.* at 121.

2. An equitable lien can be enforced only against the specifically identifiable property that is the subject of the

agreement, or its traceable product. Respondent asserts that an equitable lien can be enforced as long as the specifically identifiable property that was the subject of the lien was in the hands of the defendant at any point in time. Orange Br. 16-17. But that is simply not true.

An equitable lien entitles a plaintiff to have the specifically identifiable property that is the subject of the lien—or its traceable product—seized and sold so that the proceeds of the sale (either entirely or in part) can be paid to plaintiff. "In equity the word 'lien' . . . denotes a right of a particular nature over a thing constituting incumberance upon it and the lien may be enforced *by a proceeding against it* . . . ." 1 Leonard A. Jones, *A Treatise on the Law of Liens* § 2, at 4 (Edward M. White ed., 3d rev. ed. 1914) ("*Jones on Liens*") (emphasis added).[17] That same treatise explains further:

> [I]t is necessary that the property or funds upon which the lien is claimed should be distinctly traced, so that the very thing which is subject to the special charge may be proceeded against in an equitable action, and sold under decree to satisfy the charge.

Id. § 34, at 35.

To be clear: an equitable lien does not give the plaintiff "a right to recover a sum of money generally out of the defendant's assets." 4 Pomeroy § 1234, at 694 (describing legal contractual remedies as "mere recoveries of money"

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[17] The sentence further explains that a common law lien required the plaintiff to have possession "of the thing," but an equitable lien does not require such possession. *Jones on Liens* § 2, at 4; *see also id.* § 3, 4-5.

and equitable remedies as being "as a general rule, directed against some specific thing; they give or enforce a right to or over some particular thing,—a tract of land, personal property, or a fund,—rather than a right to recover a sum of money generally out of the defendant's assets"); *see also* Restatement (First) of Restitution § 161 cmt. e (1937).

Respondent contends that equitable liens by agreement are "merely a means to the end of satisfying a claim for the recovery of money," and that "the *real* remedy, the final object of the proceeding, is the pecuniary recovery." Orange Br. 20 (quoting *Dep't of Army v. Blue Fox, Inc.*, 525 U.S. 255, 262-63 (1999), quoting 1 Spencer W. Symons, *Pomeroy's Treatise on Equity Jurisprudence as Administered in the United States of America* § 112, at 147 (5th ed. 1941) ("1 Pomeroy")).[18] But the quoted language from the Pomeroy treatise cannot be read in isolation. The very section that Respondent cites categorizes an equitable lien as resulting in "not a *general* pecuniary judgment, but a decree of money to be obtained and paid out of some particular fund or funds." 1 Pomeroy § 112, at 147-48. It states that equitable liens and all other similar remedies are enforced "by a sale total or partial of the fund, or by a sequestration of its rents, profits, and proceeds." *Id.* at 148. And the chapter on equitable liens is similarly explicit:

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[18] There can be no serious contention that *Dep't of Army*, 525 U.S. 255, is controlling or even persuasive here, because the Court was utilizing a functional test, rather than an historical one, when it held that a suit to enforce an equitable lien was one for "money damages" within the meaning of a statute waiving sovereign immunity. *Id.* at 262-63.

> An equitable lien is simply a right of a special nature *over* the thing, . so that the very thing itself may be proceeded against in an equitable action, and either sold or sequestered under a judicial decree, and its proceeds in the one case, or its rents or profits in the other, applied upon the demand of the creditor in whose favor the lien exists.

4 Pomeroy § 1233, at 692. Because an equitable lien is "a remedy that operates directly upon [the thing concerning which the contract deals]," *id.* § 1234, at 695, it cannot be awarded unless "the thing"—a specifically identifiable *res*—is intact at the time of enforcement.

3. The enforcement of an equitable lien is limited to specifically identifiable property or its traceable product because the remedy is a powerful one: it entitles the plaintiff to priority over other creditors. Restatement (First) of Restitution § 161 cmt. c, at 652 (1937).[19]

This priority extends to any property that is traceable to the property that was initially the subject of the lien:

> Where property is subject to an equitable lien and the owner of the property disposes of it and acquires other property in exchange, he holds the property so acquired subject to the lien, in accordance with the rules stated in §§ 202-215 (Chapter 13). So

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[19] The exception is where the property has been acquired by a bona fide purchaser. *Id.* If that has occurred, the equitable lien is terminated in accordance with the "principle that a person who innocently has acquired the title to property for which he has paid value is under no duty to restore it . . . ." *Id.* § 172 cmt. a, at 692.

> also, where the property which is subject to the lien is mingled with other property in one indistinguishable mass, the lien can be enforced against the mingled mass (see § 209).

Restatement (First) of Restitution § 161 cmt. e, at 652 (1937). This is true even if the property is in the hands of third parties. If the third parties are not bona fide purchasers for value, then the plaintiff may proceed against those third parties. *Id.* § 161 cmt. d, at 652. *Cf. Jones on Liens* § 30, at 29 (equitable lien by agreement on real or personal property "will be enforced in equity, not only against [the owner of the property] but also against third persons who are either volunteers, or who take the estate on which the lien is given, with notice of the stipulation.").

But if the specifically identifiable fund that was the subject of the equitable lien has been dissipated, the equitable lien is no longer enforceable. This well-established principle was invoked in *Great-West*, 534 U.S. at 213-14, and is explicit in the Restatement:

> [I]f it is shown that the property or its proceeds have been dissipated so that no product remains, his claim is only that of a general creditor of the wrongdoer. Thus, if the wrongdoer has used the money of the claimant in speculation and has lost it all, the claimant cannot enforce a constructive trust of or an equitable lien upon other property of the wrongdoer, and has only a personal claim against the wrongdoer, and is not entitled to priority over other creditors of the wrongdoer.

Restatement (First) of Restitution § 215 cmt. a, at 867 (1937); *see also id.* § 215(1), at 866 ("[W]here a person wrongfully disposes of the property of another but the property cannot be traced into any product, the other has merely a personal claim against the wrongdoer and cannot enforce a constructive trust or lien upon any part of the wrongdoer's property."); *A. Person, Harriman & Co. v. Oberteuffer*, 59 How. Pr. 339, 341-42 (1880) ("All the cases point to one conclusion—that the identical property or its proceeds must be traced in order to uphold the [equitable] lien.").

Indeed, the plaintiff seeking the equitable lien bears the burden of proving that the specifically identifiable fund—or its traceable product—has not been dissipated. Restatement (First) of Restitution § 215 cmt. b, at 868 (1937) ("*Burden of proof.* A person whose property is wrongfully taken by another is not entitled to priority over other creditors unless he proves that the wrongdoer not only once had the property or its proceeds, but still has the property or its proceeds or property in which the claimant's property or its proceeds have been mingled indistinguishably.").

D. What the lower courts labelled an equitable lien was in fact a personal money judgment.

In awarding summary judgment to Respondent, the magistrate judge held "that any dissipation of settlement funds by Defendant is immaterial." Pet. App. 35 n.2; *see also* Pet. App. 40. He acknowledged that "*Sereboff* did not address the issue of a beneficiary's dissipation of assets because the funds there were placed in a separate account throughout the duration of the case[,]" Pet. App. 40, but he nonetheless determined that Mr. Montanile's dissipation was "insufficient to void Plaintiff's right to

enforce the reimbursement provision." Pet. App. 42. As such, he concluded that Respondent had "a right to seek reimbursement," and that "such reimbursement constitutes 'appropriate equitable relief.'" Pet. App. 44.

In the Judgment, the magistrate judge awarded Respondent "an equitable lien on [Mr. Montanile's] recovery from the third-party driver involved in the underlying car accident," but he did not limit Respondent's compensation to the portion of such "recovery" that remained in Mr. Montanile's possession. Instead, he awarded the equitable lien "in the amount of $121,044.02," Final Judgment, Mar. 18, 2014, ECF No. 46, without any concern for whether the judgment would be satisfied out of Mr. Montanile's general assets.

In affirming the Judgment, the court of appeals expressly held that Respondent "can impose an equitable lien on Montanile's settlement, even if dissipated." Pet. App. 11. But the enforcement of an equitable lien on any assets *other than* the specific property on which the lien was attached (or its traceable product) is simply personal liability—the precise type of legal relief that *Great-West* made clear is unavailable under 29 U.S.C. § 1132(a)(3).

Reversal is warranted.

III. Respondent's New Deficiency Judgment Theory Does Not Warrant Affirmance.

In its petition stage brief, Respondent repeats the only argument that it advanced in the lower courts: that a participant need not "possess the identified funds at the time of suit for a plan to enforce its equitable lien by agreement." Orange Br. 16-17. As explained above, that argument is wrong.

Respondent also advances a new theory of "equitable relief" as an alternative ground on which the decision below might be affirmed: the deficiency judgment. *See* Orange Br. 19 (citing Fed. Equity R. 10 (1912) for the proposition that "'[i]n suits for the foreclosure of mortgages, or for the enforcement of other liens, a decree may be rendered for any balance found to be due to the plaintiff over and above the proceeds of the sale or sales' of the property that was subject to the lien .").[20] As explained below, this deficiency judgment theory cannot serve as a basis for affirmance.

A. A deficiency decree is not equitable relief.

It is now clearly settled that "equitable relief" does *not* mean "whatever relief a court of equity is empowered to provide in the particular case at issue." *Mertens*, 508 U.S. at 256. As this Court has acknowledged, equity courts "could 'establish purely legal rights and grant legal remedies which would otherwise be beyond the scope of [their] authority.'" *Id.* at 256 (quoting 1 Pomeroy § 181, at 257). The mere fact that a legal remedy *could* have been granted by an equity court does not make the remedy an "equitable" one that is available under 29 U.S.C. § 1132(a)(3). And the deficiency judgment is a paradigmatic example of one such legal remedy. *In re Smith*, 270 B.R. 557, 561 (Bankr. W.D.N.Y. 2001) ("A judgment of foreclosure and sale arises out of a foreclosure, as an equitable suit. In contrast, a deficiency judgment is a legal remedy . . . that is incidental to the foreclosure.").

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[20] In making this argument, Respondent effectively concedes that an equitable lien can be enforced only against property in the hands of the defendant because the lien is enforced by selling property. If the property does not exist, then there is obviously nothing to sell.

As explained in 1934 by a law review article entitled, "Deficiency Judgments and Decrees," an action to foreclose a mortgage was equitable, but equity courts were not initially permitted to "render a personal judgment against the mortgagor or any other defendant for any deficiency." Oliver K. Eaton, *Deficiency Judgments and Decrees*, 20 Va. L. Rev. 743, 743 (1934); *see also Dunkley v. Van Buren*, 3 Johns. Ch. 330 (1818) (denying motion, in mortgage foreclosure proceeding, to require mortgagor to pay any deficiency).

There was then a "distinct advance in equity jurisprudence":

> [U]nder the rule that, where a Court of Equity obtains jurisdiction of an action, it will retain it and administer full relief, both legal and equitable, it has been held that, where a Court of Equity acquires jurisdiction for the foreclosure of a mortgage, it may retain jurisdiction for the administration of full relief, and, as a part of such relief, may render a deficiency judgment.

Eaton, 20 Va. L. Rev. at 743 (quoting 42 Corpus Juris § 1974 and stating that "[i]n support of the modified text Corpus Juris cites authorities in the United States Courts, Idaho, Kentucky, New Jersey and New Mexico"); *see also Reichert v. Stilwell*, 64 N.E. 790, 792 (1902) (explaining that equity courts previously "had no power to include a provision for deficiency in a decree of foreclosure," but a New York statute bestowed that authority as "an incidental remedy, dependent wholly upon the statute and subsidiary to the main object of the action"); *Culver v. Judge of Superior Court of Detroit*, 23 N.W. 469, 471 (Mich. 1885) (explaining that a Michigan

statute bestowed upon equity courts the power to render deficiency decrees in foreclosure suits because previously "[a] separate suit at law upon the bond or note was necessary for the recovery of the deficiency, where one arose "). It is thus clear that a deficiency decree is a legal remedy that equitable courts were sometimes permitted to award as a legal adjunct to the equitable foreclosure remedy.

B. Even if a deficiency decree is available under 29 U.S.C. § 1132(a)(3), the decision below must be reversed and remanded.

Respondent did not seek a deficiency decree in the lower courts. Thus, even if this Court finds that such a remedy is available under 29 U.S.C. § 1132(a)(3), the decision below must be reversed and remanded so that Mr. Montanile will have an opportunity to challenge its availability in this case.

There is good reason to believe that Mr. Montanile will prevail on remand. For example, the present case is substantially identical to *Fidelity Deposit Co. v. Central Bank*, 48 F.2d 477 (8th Cir. 1931). There, Plaintiff had advanced money and, as a result, had an equitable lien by assignment, which it subsequently sought to collect. The court of appeals held that the plaintiff clearly had an equitable lien on funds currently in the debtor's possession. *Id.* at 478 ("That the appellant had an equitable lien on the retained percentages in the hands of the improvement district cannot be denied.").

The court of appeals nonetheless refused to enforce the equitable lien due to the plaintiff's delay in taking action before the funds were disbursed. After notice of impending dissipation was given in August and September, the lienholder replied on October 1 that it was

referring the matter to its home office but then made no further response before the funds were disbursed on November 12. *Id.* at 479-80. The court of appeals held that the lienholder's 42 days of doing nothing vitiated its ability to obtain monetary relief: "[u]nder such circumstances, [defendants] were not called upon to hold the funds indefinitely. The rule is that 'an equitable lien may be lost by negligent and unreasonable delay in proceeding to enforce it.'" *Id.* at 480 (citing cases).[21]

The delay here of six months far exceeded the one in *Fidelity Deposit* and was even more unreasonable.[22]

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[21] Indeed, the forfeiture of the right to a deficiency judgment may occur for reasons other than negligent and unreasonable delay. *Cf Pioneer Dodge Center, Inc. v. Glaubersklee*, 649 P.2d 28, 30 (Utah 1982) (deficiency judgment barred because lienholder's sale was not handled in a commercially reasonable manner).

[22] Before he had ever disbursed any of the settlement money, Mr. Montanile's ERISA attorney, Brian King, had a valid legal basis to challenge the Respondent's claim for full reimbursement. First, he correctly observed that "the Supreme Court in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), left open the question of whether the made whole rule must be taken into account in evaluating what is 'appropriate equitable relief' authorized under 29 U.S.C. § 1132(a)(3)." JA 74 (citing *Sereboff*, 547 U.S. at 368, n.2). It took a Supreme Court opinion to resolve this question, and that decision was not issued until April 16, 2013. *See US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013). Second, Mr. King believed that the reimbursement provision was found only in the SPD and was thus unenforceable under *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1878 (2011) ("[W]e conclude that the summary documents, important as they are, provide communication with beneficiaries *about* the plan, but that their statements do not themselves constitute the *terms* of the plan for purposes of § 502(a)(1)(B)."") (emphasis in original). This is an issue on which courts continue to disagree. *See, e.g., supra* 7 n.6.

After six months of negotiation, Respondent made a "final offer,"

Thus, the longstanding rule in equity applied by the court of appeals in that case is similarly applicable here. *See also Zack v. City of Minneapolis*, 601 F. Supp. 117, 120 (D. Minn. 1985) ("[I]t is a basic principle of equity that undue delay in enforcing one's rights to the prejudice of another bars enforcement of those rights [An] equitable lien may be lost by negligent and unreasonable delay in enforcing it.").

It is beyond any serious dispute that the district court did not assess Respondent's negligence or unreasonable delay in this context. *See* Pet. App. 34-35 (noting that "[t]here is no dispute that Plaintiff filed suit against Defendant six months after the parties exchanged final settlement offers," but finding such delay legally irrelevant because "ERISA does not specify a limitations period for a fiduciary's actions to enforce a reimbursement provision [and therefore] this Court is guided by Florida's *five-year* statute of limitations for breach of written contract actions") (emphasis added).

Thus, according to the decision below, Respondent could have unreasonably delayed for one day short of *five years* and it would still be entitled to a personal money judgment against Mr. Montanile's general assets. That cannot possibly be what was intended by Congress in

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and threatened to sue if its offer was not accepted. JA 25 (¶14); JA 35 (¶11). In response, Mr. King asked that, "*if* the Plan intended to litigate the matter, it do so within 14 days." JA 35 (¶12) (emphasis added); *see also* JA 25 (¶15). And he explicitly notified Respondent that he would release the funds to Mr. Montanile if Respondent failed to file suit within that reasonable two-week period. JA 25 (¶15); JA 35 (¶12). The Plan did absolutely nothing. It did not even ask for more time to file its lawsuit. *See* JA 25 (¶¶16-17); JA 35 (¶¶13-14). Still, Mr. King waited for an additional 14 days before disbursing the settlement funds to Mr. Montanile. JA 25 (¶16); JA 35 (¶13).

limiting fiduciary remedies under 29 U.S.C. § 1132(a)(3) to "appropriate equitable relief."

IV. The Court Should Not Be Influenced by Respondent's Misguided Policy Arguments.

Respondent's primary defense of the decision below is on policy grounds. *See, e.g.*, Orange Br. 20 ("All of this points up at a bigger principle: Equity jurisdiction is founded on the maxim that equity suffers not a right to be without a remedy.") (internal quotation marks omitted). Respondent's arguments are misguided.

A. The position advanced by Petitioner and endorsed by the United States does not result in the proliferation of dissipation.

According to Respondent, "Montanile's position would create perverse incentives for beneficiaries" to spend settlement funds before the plan could act. Orange Br. 20. But, in reality, the inability of fiduciaries to reach a participant's general assets will not cause any increase in the intentional dissipation of tort settlements by injured ERISA participants.[23] The reason is simple:

Personal injury attorneys virtually never release funds without first giving the plan an opportunity to act. Indeed, ABA Model Rule 1.15(e) requires lawyers to keep separate any "property in which two or more persons . . claim interests . until the dispute is resolved." ABA

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[23] Petitioner's position is currently the law in two circuits. *See Treasurer, Trustees of Drury Indus., Inc. Health Care Plan & Trust v. Goding*, 692 F.3d 888 (8th Cir. 2012); *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083 (9th Cir. 2012). There is no evidence of a "dissipation explosion" in those jurisdictions.

Model Rule of Prof'l Conduct Rule 1.15(e) (2015). And every state has imposed a nearly identical obligation.[24]

In reality, tort settlements are typically released to and spent by an injured ERISA participant only after a plan has been notified that the lien (or its amount) is disputed and then fails to act. This case is illustrative. *See supra* 8-9 (Respondent was notified by Mr. King that funds would be released to Mr. Montanile within 14 days if no lawsuit was filed; Respondent then ceased all correspondence and waited six months before bringing

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[24] *See e.g.*, Ala. R. Prof'l Conduct 1.15(c); Alaska R. Prof'l Conduct 1.15(e); Ariz. R. Prof'l Conduct 1.15; Ark. R. Prof'l Conduct 1.15; Colo. R. Prof'l Conduct 1.15A; Conn. R. Prof'l Conduct R. 1.15(f); Del. Lawyers' R. Prof'l Conduct 1.15(c); R. Regulating Fla. Bar 5-1.1(f); Ga. R. Prof'l Conduct 1.15(I)(d); Haw. R. Prof'l Conduct 1.15; Idaho R. Prof'l Conduct 1.15(e); Ill. R. Prof'l Conduct 1.15(c); Ind. R. Prof'l Conduct 1.15; Iowa R. Prof'l Conduct 32:1.15; Kan. R. Prof'l Conduct 1.15; Ky. S. Ct. R. 3.310 (1.15); La. R. Prof'l Conduct 1.15(e); Me. R. Prof'l Conduct 1.15; Md. Lawyers' R. Prof'l Conduct 1.15; Mass. R. Prof'l Conduct 13:207; Mich. R. Prof'l Conduct 1.15; Minn. R. Prof'l Conduct 1.15; Miss. R. Prof'l Conduct 1.15; Mo. R. Prof'l Conduct 4-1.15(e); Mont. R. Prof'l Conduct 1.15; Neb. Ct. R. of Prof. Cond. § 3-501.15(e); Nev. R. Prof'l Conduct 1.15; N.H. R. Prof'l Conduct 1.15; N.J. R. Prof'l Conduct 1.15; N.M. R. Prof'l Conduct 16-115; N.Y. R. Prof'l Conduct R. 1.15(b)(4); N.C. R. Prof'l Conduct 1.15-2; N.D. R. Prof'l Conduct 1.15; Ohio R. Prof'l Conduct 1.15; Okla. R. Prof'l Conduct 1.15; Or. R. Prof'l Conduct 1.15-1; Pa. R. Prof'l Conduct 1.15; R.I. R. Prof'l Conduct 1.15; S.C. R. Prof'l Conduct 1.15; S.D. R. Prof'l Conduct 1.15; Tenn. R. Prof'l Conduct 1.15; Tex. Disciplinary R. Prof'l Conduct 1.14; Utah R. Prof'l Conduct 1.15; Vt. R. Prof'l Conduct 1.15; Va. R. Prof'l Conduct 1.15; Wash. R. Prof'l Conduct 1.15A; W. Va. R. Prof'l Conduct 1.15; Wis. R. Prof'l Conduct for Attorneys 20:1.15; Wyo. R. Prof'l Conduct for Attorneys at Law 1.15(f); *see also Johnstone v. State Bar of Cal.*, 410 P.2d 617, 618 (Cal. 1966).

suit). To be blunt: the rule advanced by Respondent is a solution in search of a problem.

B. The position advanced by Petitioner and endorsed by the United States does not leave ERISA fiduciaries without a remedy.

According to Respondent, "Montanile's position would leave plans with no way to enforce their otherwise-valid reimbursement provisions " Orange Br. 20. Respondent's speculation is unfounded and overblown.

1. If a participant or beneficiary does not agree to preserve disputed settlement funds, plans can sue under 29 U.S.C. § 1132(a)(3) to enjoin the dissipation of funds and can take immediate steps to have those funds preserved. And in truly exceptional cases where the participant has already spent some or all of the settlement funds, the robust nature of the equitable lien remedy provides significant protection:

- If the participant has used settlement funds to obtain an asset, the plan can trace the settlement funds to the purchase of that asset and can enforce the equitable lien against that asset. Restatement (First) of Restatement § 161 cmt. e, at 652 (1937).
- If the participant *gives* the settlement funds to another person, the plan can trace the settlement funds to that person and enforce the equitable lien against that person. *Id.* § 161 cmt. d, at 652.
- If the participant uses the settlement fund to obtain goods or services from another person with notice of the lien, the plan can trace and collect the settlement funds from that person as well. *Id.*

The plan is left without a remedy only if, after the plan fails to act, the participant uses the settlement funds to purchase services (*e.g.*, childcare) or consumable goods (*e.g.*, food) from a bona fide purchaser for value.

2. What Respondent decries is not the absence of a meaningful remedy but rather the absence of *its preferred remedy*—money damages for breach of contract. That is ironic given the unprecedented subrogation/reimbursement tools available to an ERISA plan that are unavailable under the laws of virtually every one of the fifty states. *See generally* Brendan S. Maher & Radha A. Pathak, *Understanding and Problematizing Contractual Tort Subrogation*, 40 Loy. U. Chi. L. J. 49 (2008). *See also* Matthiesen, Wickert & Lehrer, S.C., *Med Pay/PIP Subrogation in All 50 States* (last updated April 16, 2015), https://www.mwl-law.com/wp-content/uploads/2013/03/med-pay-pip-subrogation-in-all-50-states1.pdf (summarizeing the relevant subrogation law in each of the 50 states).

This dispute is illustrative. Respondent's own documents provided for a right of subrogation. Pet. App. 5. Respondent could have pursued the tortfeasor directly and ensured that it recouped the medical expenses advanced to Mr. Montanile. Alternatively, it could have protected its interest by intervening in Mr. Montanile's lawsuit against the tortfeasor. *See* Fla. R. Civ. P. 1.230; *Union Cent. Life Ins. Co. v. Carlisle*, 593 So.2d 505 (Fla. 1992) (permitting insurer to intervene in insured's tort suit but limiting insurer's involvement). Either approach would have been more efficient than the sit-on-its-hands approach the Plan chose to take.

C. Any plea for more robust civil remedies should be directed at Congress.

Even if Respondent were correct that the position advanced by Mr. Montanile and endorsed by the United States will leave fiduciaries without a meaningful remedy for certain violations of ERISA, that is no reason to ignore the text of 29 U.S.C. § 1132(a)(3) as consistently interpreted by this Court for over two decades.

Dissatisfaction with this Court's interpretation of 29 U.S.C. § 1132(a)(3) is not new. For example, in direct response to *Great-West* and concerns expressed by ERISA plan fiduciaries, current Speaker of the United States House of Representatives John A. Boehner sponsored a bill which included an amendment to section 502(a)(3) of ERISA that is the very embodiment of Respondent's position here. Pension Protection Act of 2005, H.R. 2830, 109th Cong. § 307 (2005). It failed.

Like fiduciaries, advocates for ERISA plan participants and beneficiaries have also expressed dissatisfaction with this Court's interpretation of 29 U.S.C. § 1132(a)(3). For years, they have complained that this Court's narrow reading of the phrase "equitable relief"—coupled with ERISA's broad preemption provision—leaves aggrieved workers and their beneficiaries without any remedy for clear statutory violations which often result in catastrophic injuries. *See generally* Paul M. Secunda, *Sorry, No Remedy: Intersectionality and the Grand Irony of ERISA*, 61 Hastings L.J. 131 (2009).[25]

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[25] In one infamous case where a child failed to survive because of a Plan's wrongful determination that hospitalization of the mother

In response to this "regulatory vacuum," *see Aetna Health Inc. v. Davila*, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring), there have been several legislative proposals to override this Court's past decisions interpreting the meaning of "appropriate equitable relief" in 29 U.S.C. § 1132(a)(3). *See, e.g.*, Omnibus Budget Reconciliation Act of 1993, S. 1134, 103d Cong. § 12312(a) (1993) (proposed amendment to 29 U.S.C. § 1132(a)(3) introduced in Senate three weeks after *Mertens* decision); Employee Pension Freedom Act of 2002, H.R. 3657, 107th Cong. § 403(c) (2002) (proposed amendment to 29 U.S.C. § 1132(a)(3) introduced in House three weeks after *Great-West* decision); Intergenerational Financial Obligations Reform Act of 2002, S. 2032, 107th Cong. § 403(c) (2002) (proposed amendment to 29 U.S.C. § 1132(a)(3) introduced in Senate three months after *Great-West* decision). These attempts also failed.

Put simply, Congress is aware that 29 U.S.C. § 1132(a)(3) sometimes leaves aggrieved ERISA stakeholders without a remedy. And Congress—not this Court—is the body to which any request to amend ERISA should be directed. *See Mertens*, 508 U.S. at 254, 262 (noting that ERISA is a "carefully crafted and detailed enforcement scheme" that "resolved innumerable disputes between competing interests ").

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was not medically necessary, the district court found that the plaintiff nonetheless had no remedy under ERISA. *See Corcoran v. United Healthcare, Inc.*, No. CIV. A. 90-4303, 1991 WL 353841 (E.D. La. Apr. 3, 1991). In affirming the district court, the Fifth Circuit expressly noted that "[t]he acknowledged absence of a remedy under ERISA's civil enforcement scheme for medical malpractice committed in connection with a plan benefit determination does not alter our conclusion. . . " *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1333 (5th Cir. 1992).

CONCLUSION

For the reasons set forth above, the judgment of the Eleventh Circuit should be reversed and the case remanded for further proceedings.

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IN THE
Supreme Court of the United States

ROBERT MONTANILE,
Petitioner,
v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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QUESTION PRESENTED

Whether a beneficiary of a benefit plan governed by the Employee Retirement and Income Security Act of 1974 (ERISA) can defeat enforcement of the plan's valid equitable lien by agreement—after the lien attached—by spending the funds subject to the lien.

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Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF FOR RESPONDENT

INTRODUCTION

Respondent Board of Trustees of the National Elevator Industry Health Benefit Plan paid over $120,000 of Petitioner Robert Montanile's medical bills when he was injured by a drunk driver. The Plan did so on the express condition that Montanile reimburse the Plan out of any tort recovery he obtained. Montanile subsequently recovered a $500,000 settlement from the drunk driver and his insurance.

In this Court, Montanile agrees that at the time he received the settlement funds, he was under a duty in equity, enforceable by ERISA's civil remedies, to use it to repay the Plan. Montanile nonetheless argues that he successfully voided this duty, and his written agreement memorializing it, because he

spent the settlement money (or, at least, most of it) before the Plan sued him to recover the money that it had paid on his behalf. That self-interested argument—that a beneficiary may break his promises to a plan with impunity—has no support in this Court's cases, in equity, or in common sense.

When a beneficiary like Montanile does not live up to his promises, Congress authorized the plan fiduciary to enforce the plan's reimbursement provision against the unwilling beneficiary through ERISA's Section 502(a)(3), which allows a plan fiduciary "to obtain other appropriate equitable relief" to "enforce * * * the terms of the plan." 29 U.S.C. § 1132(a)(3)(B). Such a suit, this Court has explained, is equivalent to an action in equity to enforce an "equitable lien by agreement"—a traditional and appropriate equitable remedy. *US Airways, Inc.* v. *McCutchen*, 133 S. Ct. 1537, 1544-45, 1547 (2013). The question presented is whether Montanile's dissipation of the funds allows Montanile to escape his otherwise-enforceable reimbursement obligation.

The answer under the statute, this Court's caselaw, and historical equity practice is no. To establish its right to recover, the Plan had to prove three things—and only three things: (1) Montanile agreed to repay money out of any third-party tort settlement, (2) the settlement fund from which Montanile agreed to make repayment was specifically identified, and (3) Montanile came into possession of that fund. *See Sereboff* v. *Mid Atl. Med. Servs.*, 547 U.S. 356, 363-364 (2006).

Montanile's argument is also contrary to a cardinal principle of equity jurisprudence. The first maxim of equity is that "'equity suffers not a right to be with-

out a remedy.'" *CIGNA Corp.* v. *Amara*, 131 S. Ct. 1866, 1879 (2011) (quoting Richard Francis, *Maxims of Equity* 29 (1st Am. ed. 1823)); *see also Marbury* v. *Madison*, 5 U.S. 137, 163 (1803) (" 'It is a general and indisputable rule, that where there is a legal right, there is also a legal remedy by suit * * * when ever that right is invaded.' ") (quoting 3 William Blackstone, *Commentaries* *23). And yet, that is precisely what Montanile asks this Court to hold.

Montanile's equitable argument—that a plan's right to enforce a reimbursement obligation terminates the moment a beneficiary spends the money—rests on principles that apply to a *different* type of equitable remedy: restitution for unjust enrichment. *See Great-West Life & Annuity Ins. Co.* v. *Knudson*, 534 U.S. 204 (2002). Equitable restitution for unjust enrichment examines whether certain funds can be traced to the present possession of a defendant. However, *Sereboff* clarified that the "strict tracing rules" described in *Great-West* were applicable *only* to equitable restitution—not equitable liens by agreement. 547 U.S. at 364. *Great-West* had "simply described in general terms the conditions under which a fiduciary might recover when it was seeking equitable restitution"; "[t]here was no need * * * to catalog all the circumstances in which equitable liens were available in equity." *Id.* at 365. It "concluded only that equitable *restitution* was unavailable because the funds sought were not in [the beneficiary's] possession." *Id.* (emphasis added). There was no such requirement for an equitable lien by agreement. *Id.* at 364-365.

The Plan's interpretation of ERISA to permit recovery here stays true to this Court's teaching that the plan terms are "at the center of ERISA."

McCutchen, 133 S. Ct. at 1548. The Plan required reimbursement from a tort recovery as a condition of its upfront payment of Montanile's medical bills; Montanile received a tort recovery and declined to honor his reimbursement obligation. To ensure that the Plan's right to reimbursement is not "'without a remedy'" under the statute, the Court should affirm. *CIGNA*, 131 S. Ct. at 1879 (citation omitted).

STATUTORY PROVISIONS INVOLVED

Relevant statutory provisions are reprinted in the addendum to this brief.

STATEMENT

1. Petitioner Robert Montanile was a beneficiary of a welfare benefit plan administered by the Respondent, the Board of Trustees of the National Elevator Industry Health Benefit Plan. Pet. App. 2a-3a. The Plan is self-funded, J.A. 38, which means that "it does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants." *FMC Corp.* v. *Holliday*, 498 U.S. 52, 54 (1990). Like all plans governed by ERISA, the Plan's Trustees must "preserve [Plan] assets to satisfy future, as well as present, claims" and "take impartial account of the interests of all beneficiaries." *Varity Corp.* v. *Howe*, 516 U.S. 489, 514 (1996).

To carry out that fiduciary duty, J.A. 43-44, the Plan's Trustees have adopted Plan provisions that ensure the Plan's assets are not used to pay for medical expenses that should be—and can be—reimbursed through other sources. J.A. 45-49. The Plan provides that when a beneficiary is injured through the fault of another, "the Plan is only obligated to provide covered benefits resulting from that

*** injury that exceed any amounts recovered from another party." J.A. 45. But the Plan also recognizes it can be unfair for a beneficiary's medical bills to accumulate while a legal claim winds its way through the courts. The Plan therefore offers to advance benefits to its injured beneficiary so long as the Plan's rights are protected. J.A. 46.

The Plan is explicit. It states that "[a]cceptance of benefits from the Plan for an injury or illness by a covered person, without any further action by the Plan and/or the covered person, constitutes an agreement that any amounts recovered from another party" will "promptly be applied first to reimburse the Plan in full for benefits advanced by the Plan." *Id.* The Plan also provides that, by virtue of the beneficiary's reimbursement agreement, "[a]mounts that have been recovered by a covered person from another party are assets of the Plan." J.A. 45. And the Plan clarifies that it is owed reimbursement in full "without reduction for attorneys' fees, costs, expenses or damages claimed by the covered person, and regardless of whether the covered person is made whole or recovers only part of his/her damages." J.A. 46.

The Plan goes even further, actively ensuring that Plan beneficiaries are aware of the obligations they undertake when they accept advance medical benefits. It states that "[p]rior to advancement of a benefit by the Plan to a covered person *** for any expense or loss for which there may be a claim against another party, a covered person must execute a written document acknowledging the Plan's right of recovery." J.A. 47. The Plan also makes its standard acknowledgment form available on its website. *See* National Elevator Industry Benefit

Plans, Acknowledgment of Summary Plan Description Provisions/Subrogation, https://goo.gl/epoSAB. The Plan is clear, however, that a beneficiary is obligated to reimburse the Plan even if the beneficiary does not execute the written acknowledgment. J.A. 48.

2. When Montanile was injured by a drunk driver, he asked the Plan advance his medical expenses and signed an acknowledgment "agree[ing] to reimburse, in full, [the Plan] to the extent of any recovery * * * as a result of any legal action or settlement or otherwise." J.A. 51. In reliance on Montanile's explicit agreement to reimburse it, the Plan paid $121,044.02 of Montanile's medical bills while Montanile's suit against the drunk driver and his claim for underinsured motorist benefits proceeded. J.A. 39-40.

Montanile eventually settled his legal claims for $500,000. J.A. 40. But rather than honor his reimbursement obligation, Montanile stonewalled, hiring an attorney who resisted the Plan's reimbursement rights at every turn. First, the attorney demanded that the Plan answer several detailed questions—some involving multiple subparts—proving its entitlement to reimbursement. J.A. 68-74. The Plan sent the attorney many of the requested documents, including the Plan provisions outlining Montanile's reimbursement obligation. J.A. 24.

Montanile's attorney then asserted that the reimbursement obligation was unenforceable. *Id.* The Plan disagreed, but offered to compromise its lien. J.A. 24-25. Montanile's attorney made a counteroffer, which the Plan rejected in favor of its own, best-and-final offer to settle the case. J.A. 25.

Montanile refused to accept the Plan's settlement proposal. Instead, Montanile's attorney made an ultimatum shortly after New Year's: If the Plan did not sue in 14 days, he would release the settlement funds to Montanile. J.A. 25. And when the Plan did not immediately respond, Montanile's attorney made good on his threat. *Id.*; J.A. 78-80.

In dispersing Montanile's settlement, his counsel looked out for all of Montanile's creditors—except the Plan. Montanile's attorneys took $200,000 off the top as a 40% contingency fee. J.A. 78. They also took $63,788.48 as reimbursement for their costs. J.A. 79. Montanile's attorneys then ensured that $1,213.22 in Montanile's out-of-pocket medical expenses were paid. J.A. 78. And they set aside $37,581.95 to repay various personal loans Montanile had taken out, to satisfy a child-support lien, and to bring current Montanile's back union dues. J.A. 79. And even with all of those deductions, Montanile received $197,416.35—more than enough to repay the Plan's lien. *Id.*[1]

3. The Plan sued Montanile in July 2012, seeking to enforce his reimbursement obligation. Pet. App. 24a-25a. Montanile primarily asserted three defenses to the Plan's action. First, he argued that the documents the Plan relied on did not create an enforceable equitable lien by agreement. Pet. App. 26a. Second, he argued that the Plan's six-month delay in bringing suit barred enforcement of

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[1] Montanile misleadingly claims that less than $90,000 remained to compensate him for his injuries. Montanile Br. 5. That figure ignores that Montanile claims to have received—and spent—the over $100,000 belonging to the Plan. J.A. 79.

its lien under laches. Pet. App. 34a. Finally, he argued that he had spent most of his settlement, which, in his view, prevented the Plan from obtaining an equitable lien by agreement. Pet. App. 35a; *see also* J.A. 57 (Montanile's admission that he still possessed a "small portion" of his settlement).

The District Court disagreed. It held that the Plan documents created an enforceable equitable lien by agreement. Pet. App. 25a-30a. It further held that it was "unaware of any authority * * * that provides a basis to conclude that * * * [the Plan's] timeframe for filing suit was unreasonable, inexcusable, or prejudicial" as to justify laches. Pet. App. 34a.

The District Court then turned to Montanile's dissipation argument. It recognized that there were substantial questions as to whether Montanile had, in fact, dissipated his settlement. His counsel's disbursement sheet, for instance, "raise[d] more questions than [it] answer[ed]." Pet. App. 35a n.2. But following the "overwhelming majority of circuit courts," the District Court held any dispute over dissipation was "immaterial when a fiduciary asserts an equitable lien by agreement." Pet. App. 40a. So long as Montanile had possessed the funds at some point—and he had—Montanile could not evade the Plan's lien by spending the money he had promised to turn over. Pet. App. 42a. The court therefore entered judgment in the Plan's favor in the amount of $121,044.02. Dkt. No. 46 (Final Judgment).

4. Montanile appealed to the Eleventh Circuit, which affirmed. Pet. App. 1a-18a. On appeal, Montanile abandoned the laches argument he had advanced in the District Court. He argued instead that the Plan's documents did not create an equitable lien

by agreement, and that, even if they did, his alleged dissipation of the settlement funds prevented the Plan from obtaining an enforceable lien. Montanile C.A. Opening Br. 15-36.

The Eleventh Circuit, like the District Court before it, disagreed. It held that the Plan documents created an enforceable equitable lien by agreement. Pet. App. 12a-17a. And applying its recent decision in *AirTran Airways Inc.* v. *Elem*, 767 F.3d 1192 (11th Cir. 2014) (reprinted at Pet. App. 46a-76a), it held that Montanile's claimed dissipation could not defeat the Plan's otherwise valid lien. Pet. App. 10a-11a.

In *Elem*, the Eleventh Circuit rejected a dissipation argument identical to Montanile's. The court of appeals held that "[i]t matters not whether the settlement funds have since been disbursed or commingled with other funds." Pet. App. 53a. Rather, "[a]s soon as the settlement fund was identified, the plan imposed an equitable lien over that fund even though it was in the hands of the beneficiaries." Pet. App. 54a. And the "'[p]roperty to which the lien attached may be converted into other property without affecting the efficacy of the lien.'" *Id.* (quoting *Funk* v. *CIGNA Grp. Ins.*, 648 F.3d 182, 194 (3d Cir. 2011)). As a result, even where a plan beneficiary "willfully refuse[s] to abide by the terms of" a plan, the beneficiary's "dereliction *** could not destroy the lien that attached" before dissipation. *Id.*

5. Montanile petitioned for *certiorari*. In his petition, Montanile did not argue that the Plan's lien was barred by laches. Montanile also affirmatively abandoned his argument that the Plan documents did not create an equitable lien by agreement,

Pet. 11 n.4, a strategic concession Montanile admits that he made in order to "maximize the likelihood of further review," Montanile Br. 13 n.8. Montanile instead elected to present a single question: Whether he could defeat the Plan's otherwise-valid lien by claiming to have spent the settlement funds on things other than complying with the repayment obligation he acknowledges was valid. Pet. i. On the express understanding that Montanile's petition was limited to the dissipation question, the Plan agreed *certiorari* was warranted. Resp. Cert. Br. 14.

This Court granted the writ. 135 S. Ct. 1700 (2015).

SUMMARY OF ARGUMENT

Plan fiduciaries may enforce plan reimbursement provisions by suing participants and beneficiaries under ERISA Section 502(a)(3) for "appropriate equitable relief." That statutory phrase incorporates "those categories of relief that were *typically* available in equity." *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 256 (1993). The District Court awarded just that type of relief to the Plan: an equitable lien by agreement. And the Eleventh Circuit rightly affirmed. This Court should, too. The decision below is consistent with the Court's caselaw, ERISA's text, and its purpose; it follows historical equitable practice at the time of the divided bench; and it avoids the burdens on plans, beneficiaries, and courts alike that Montanile's approach would impose.

I. Montanile claims error because, despite his promise to reimburse the Plan out of any settlement proceeds, he dissipated the settlement fund after making that promise. He argues that the dissipation precludes the Plan from seeking equitable relief

under *Great-West*, 534 U.S. 204. To be sure, *Great-West* did hold that an ERISA plaintiff pursuing an *equitable restitution* theory must trace the promised fund to the defendant's present possession. *See id.* at 213. But this Court made clear in *Sereboff* that there is no such requirement for *equitable liens by agreement*. *See* 547 U.S. at 364-365. Montanile's argument based on the tracing rules for equitable restitution is "improperly mixing and matching rules from different equitable boxes." *McCutchen*, 133 S. Ct. at 1546.

To establish the equitable lien, the Plan had to prove three things: (1) Montanile agreed to repay money out of any third-party tort settlement, (2) the settlement fund from which Montanile agreed to make repayment was specifically identified, and (3) Montanile came into possession of that fund. *See Sereboff*, 547 U.S. at 363-364. Because the Plan established all three, it was entitled to enforce its lien.

This result is both simple and correct. It allows plan fiduciaries to enforce ERISA plans according to their terms. It holds plan participants to their promises. And it honors ERISA's text and purpose.

II. Enforcing the Plan's equitable lien by agreement is also entirely consistent with "the standard current works" and cases from "the days of the divided bench." *Great-West*, 534 U.S. at 212, 217. Historical equitable practice would not leave the Plan without a remedy; equity's first, foundational maxim is that "'equity suffers not a right to be without a remedy.'" *CIGNA*, 131 S. Ct. at 1879 (quoting Francis, *Maxims of Equity* 29).

To that end, in equity, an equitable lien by agreement attached—and a remedy was available in equity—as soon as the promisor received the pledged fund. Neither the lien itself nor its enforcement in equity required the promisor to possess the fund at the time of suit. And even if a promisor dissipated the fund, equity provided subsidiary remedies—such as substitutionary monetary decrees and deficiency judgments—to hold the promisor to his agreement. Nothing in historical equity practice would leave a promisee like the Plan without recourse or condone a promisor like Montanile walking away from his agreements with impunity. For this reason also, the Plan was rightly awarded an equitable lien by agreement.

III. Finally, the decision below comports with common sense. If Montanile's view were adopted, plan-administration costs would increase because a plan would have to trace the present location of a promised fund every time it wanted to enforce a reimbursement obligation. And if the plan did not act fast enough to seek the extraordinary and drastic remedy of a preliminary injunction, the plan would lose its right to reimbursement. This in turn could threaten plan stability, increase premiums, and—most perversely—discourage employers from offering benefits plans that provide advance payments for medical expenses. That result should be rejected.

ARGUMENT

I. THE DECISION BELOW IS CONSISTENT WITH ERISA'S TEXT, ITS PURPOSE, AND THIS COURT'S CASELAW.

A. *Sereboff* Confirms That The Court Of Appeals Was Correct.

1. *Sereboff* the last of a trilogy of cases (*Mertens*, *Great-West*, and *Sereboff*) that define the meaning of "equitable relief" in ERISA Section 502(a)(3). None supports a present-possession requirement for the equitable remedy at issue here: the equitable lien by agreement.

a. *Mertens* did not involve equitable liens by agreement. Rather, a group of pension plan beneficiaries brought suit under Section 502(a)(3) against a non-fiduciary for "monetary relief for all losses their plan sustained as a result of the alleged breach of fiduciary duties." 508 U.S. at 255. The question presented was whether this request fell within the parameters of Section 502(a)(3).

The Court held that it did not. Although the Court had "never interpreted the precise phrase 'other appropriate equitable relief'" in ERISA, it had "construed the similar language of Title VII * * * to preclude 'awards for compensatory or punitive damages.'" *Id.* (quoting *United States* v. *Burke*, 504 U.S. 229, 238 (1992), in turn referencing 42 U.S.C. § 2000e-5(g)). The Court construed ERISA Section 502(a)(3) consistently with Title VII. It concluded that "equitable relief" in ERISA Section 502(a)(3) means "those categories of relief that were *typically* available in equity (such as injunction, mandamus,

and restitution, but not compensatory damages)." *Id.* at 256.

b. Next came *Great-West*—which also did not involve equitable liens by agreement. There, Great-West, as assignee of an ERISA plan, filed a Section 502(a)(3) action against the Knudsons, beneficiaries of the plan. The plan paid the Knudsons' medical expenses following a car accident, and the Knudsons later reached a substantial tort settlement with a third party for their injuries. Great-West sought specific performance of the plan's reimbursement provision out of that settlement. But the settlement funds at issue had already been distributed to the Knudsons' attorney and a special needs trust established under state law. 534 U.S. at 207-208.

Great-West argued that it could nonetheless pursue a Section 502(a)(3) claim against the Knudsons because it was seeking restitution, a remedy traditionally available in equity. The Court disagreed, reasoning that the type of restitution that Great-West sought was legal in nature. *Id.* at 213. The Court explained, "for restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession." *Id.* at 214.

That rule disposed of Great-West's claims because the Knudsons "never had possession or control of the funds identified for recovery (the settlement)." *Thurber* v. *Aetna Life Ins. Co.*, 712 F.3d 654, 664 (2d Cir. 2013) (describing *Great-West*); *accord Great-West* Br. of *Amicus Curiae* in Support of the Judgment Below By Invitation of the Court 23, 2001 WL 740878 (the Knudsons "did not in fact ever receive

any money in the tort suit"). *Contra* Montanile Br. 25 n.15; U.S. Br. 15. Instead, "[a]s the order of the state court approving the settlement makes clear, the disbursements from the settlement were paid by two checks, one made payable to the Special Needs Trust and the other to respondents' attorney." *Great-West*, 534 U.S. at 214.[2] "The kind of restitution that petitioners seek, therefore, is not equitable—the imposition of a constructive trust or equitable lien on particular property—but legal—the imposition of personal liability for the benefits that they conferred upon respondents." *Id.*

c. Finally, there is *Sereboff*. The plaintiff was an ERISA plan administrator, Mid Atlantic, who brought a Section 502(a)(3) action against plan beneficiaries, the Sereboffs, to enforce the plan's reimbursement provision against a third-party tort settlement. The Court recognized that the case "involved facts similar to those" in *Great-West*. 547 U.S. at 362. Yet the Court unanimously concluded that, unlike in *Great-West*, the plaintiff in *Sereboff* was entitled to relief because it was seeking the right equitable remedy: an equitable lien by agreement. *Id.* at 363-365, 369. In so holding, the Court made three key rulings.

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[2] Montanile disputes the significance of this fact, suggesting that the Knudsons had at least constructive possession over the funds held by their attorney. *See* Montanile Br. 25 & n.15. But Great-West never made that argument, it played no role in the Court's decision, and, in any event, because the state court directed how the Knudsons' settlement funds were to be disbursed, *see* 534 U.S. at 214, the Knudsons had no ability to direct a different disposition.

First, the Court held that "the nature of the recovery" that Mid Atlantic pursued was equitable because "it sought its recovery through a constructive trust or equitable lien on a specifically identified fund." *Id.* at 363. To be sure, the fund was "within the possession and control of the Sereboffs." *Id.* Possession had played a key role in the analysis in *Great-West* because that case involved equitable restitution; "one feature of equitable restitution was that it sought to impose a constructive trust or equitable lien on 'particular funds or property in the defendant's possession.'" *Id.* at 362 (quoting *Great-West*, 534 U.S. at 213). But *Sereboff* adopted no similar requirement for the different form of equitable relief it addressed, equitable liens by agreement. *Sereboff* held that so long as the plaintiff "seek[s] to recover a particular fund from the defendant," the "nature of the recovery" is equitable. *Id.* at 363.

Second, the Court identified three elements of an equitable lien by agreement that made the "basis for [the] claim" equitable. *Id.* There must be a promise "'to convey a specific object.'" *Id.* (quoting *Barnes* v. *Alexander*, 232 U.S. 117, 121 (1914)). If the "object" is a fund, it must be a "particular fund, distinct from the [defendant's] general assets." *Id.* at 364. And finally, the defendant must come into possession of the fund. *Id.* When those requirements are met, the plaintiff can "follow" the money "into the [defendant's] hands" and "impose * * * a constructive trust or equitable lien" "as soon as the settlement fund [is] identified." *Id.* (brackets added by *Sereboff* removed) (quoting *Barnes*, 232 U.S. at 123).

Third, after explaining why the "nature of the recovery" and the "basis for [the] claim" were equitable, *id.* at 363, the Court reiterated that it was *not* adopt-

ing for equitable liens by agreement the "strict tracing rules" that *Great-West* had held were applicable to equitable restitution, *id.* at 364. *Sereboff* explained that *Great-West* did not "catalog all the circumstances in which equitable liens were available in equity"; it "simply described in general terms the conditions under which a fiduciary might recover when it was seeking equitable restitution." *Id.* at 365. But "an equitable lien sought as a matter of restitution, and an equitable lien by agreement * * * [are] different species of relief." *Id.* at 364-365 (quotation marks omitted). And no one—not even the Sereboffs—had ever "suggested * * * that any tracing was historically required when an equitable lien was imposed by agreement." *Id.* at 365 (emphasis removed) (quoting the Sereboffs' reply brief). Thus, "restitutionary tracing rules" did not apply to equitable liens by agreement. *Id.*

d. Montanile and the United States view this line of cases differently. They would stretch *Great-West*'s language suggesting a defendant must have present possession of the disputed fund to encompass every form of equitable relief available under Section 502(a)(3). *See* Montanile Br. 23-26; U.S. Br. 13-16. But *Great-West* is not so broad. *Great-West* addressed equitable restitution and equitable restitution alone. *See id.* at 214 (explaining requirements "for restitution to lie in equity"); *id.* at 229 (Ginsburg, J., dissenting) (recognizing that the equitable claim at issue was based on unjust enrichment only: "Great-West sued to recover an amount representing the Knudsons' unjust gain, rather than Great-West's loss); *see also Great-West* U.S. Br. 10, 14, 2001 WL 506039 (same). No one—not the parties, not the *amici*, and not any member of the Court—mentioned

equitable liens by agreement even once. *Cf. Great-West* U.S. Br. 24, 2001 WL 506039 (discussing only the type of "equitable lien" that is "intended to prevent unjust enrichment").

In addition, Montanile and the United States unduly minimize *Sereboff*'s third ruling, which rejected *Great-West*'s tracing rules for equitable liens by agreement. They argue that *Sereboff* rejected only restitution's requirement that the funds be traced from *the plaintiff's* hands. And they contend that, in any event, *Sereboff* left untouched the language in *Great-West* that the nature of the recovery is equitable only if the defendant presently possess the disputed fund. Montanile Br. 26-29; U.S. Br. 13-17. *Great-West* and *Sereboff* squarely refute this portrayal.

Great-West mentioned tracing exactly once, when it explained that "a plaintiff could seek restitution in equity * * * where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession." 534 U.S. at 213 (emphasis removed). Thus, although equitable restitution also required that the identified money "belong[ed] in good conscience to the plaintiff," the *tracing* component required that the funds at issue be "in the defendant's possession." *Id.*

Sereboff declined to apply that principle to equitable liens by agreement. Indeed, *Sereboff* distinguished *Great-West* on just that ground: "the Court concluded only that *equitable restitution* was unavailable because the funds sought *were not in Knudson's possession*." 547 U.S. at 365 (emphases added). For equitable liens by agreement, by contrast, a plan

fiduciary need not prove that the fund is presently in the defendant's possession. Rather, the fiduciary is "'authorized to seek payment of his debt from the property *or its value*.'" *Id.* at 367-368 (emphasis added) (quoting *Walker* v. *Brown*, 165 U.S. 654, 666 (1897)).

2. The decision below closely hews to this Court's precedents. As the District Court ruled, and the Eleventh Circuit affirmed, Montanile promised to reimburse the Plan for his medical payments out of a specific fund: the third-party recovery he received. Pet. App. 15a, 17a, 28a, 43a. Accordingly, the Plan could "'follow' a portion of the recovery 'into [Montanile's] hands' 'as soon as [the settlement fund] was identified,' and impose on that portion a constructive trust or equitable lien." *Sereboff*, 547 U.S. at 364 (quoting *Barnes*, 232 U.S. at 123) (second alteration by *Sereboff*). The equitable lien "attached not later than" "the moment the fund was received." *Barnes*, 232 U.S. at 121, 122; *see also* U.S. Br. 20 n.4 (agreeing that "the lien attached when the funds came into petitioner's possession") (ellipsis and quotation marks omitted). And because Montanile indisputably came into possession of the settlement fund, the Plan was "'authorized to seek payment'" in the form of the fund's "'value.'" *Sereboff*, 547 U.S. at 368 (quoting *Walker*, 165 U.S. at 666). Dissipation of the settlement proceeds did not bar the Plan's recovery. Pet. App. 11a, 53a-55a.

B. The Decision Below Honors ERISA's Text and Purpose.

ERISA Section 502(a)(3) allows the Plan to seek "appropriate equitable relief" from Montanile. The court of appeals rightly held that the Plan sought

just such relief. Its decision upholds the foundational principles of "uniformity," "efficiency," and "predictability" that drive ERISA. *Conkright* v. *Frommert*, 559 U.S. 506, 518 (2010).

1. The Plan's approach to Section 502(a)(3) gives full meaning to the phrase "equitable relief." It forces a Plan to take the bitter with the sweet, and incorporates the elements of equitable claims that limit the available remedy in ways that regular breach-of-contract actions at law do not. A plan fiduciary seeking to impose an equitable lien by agreement cannot simply point to any contractual breach and demand damages as compensation. Instead, the fiduciary must prove that the defendant has failed to honor a promise to pay the fiduciary money out of a specific fund that came into the defendant's hands. *See Sereboff*, 547 U.S. at 363-364. An equitable lien by agreement focuses on recovery of the promised fund, rather than the monetization of the harm caused by a breach; that distinction makes the remedy available in equity distinct from the remedy available at law.

2. a. The Plan's approach also comports with core ERISA principles. ERISA " 'is built around reliance on the face of written plan documents.' " *McCutchen*, 133 S. Ct. at 1548 (quoting *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 83 (1995)). This Court has time and again reiterated the importance of that reliance. If a plan is administered and enforced according to its terms, the expectations of the participating employers, fiduciaries, employees, and beneficiaries are protected. This works to the benefit of everyone: it "enable[s] plan beneficiaries to learn their rights and obligations at any time." *Curtiss-Wright*, 514 U.S. at 83. It " 'induc[es] employers to

offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime.'" *Conkright*, 559 U.S. at 517 (quoting *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 379 (2002)). And it fulfills "ERISA's requirements that plans be administered, and benefits be paid, in accordance with plan documents." *Egelhoff* v. *Egelhoff ex rel. Breiner*, 532 U.S. 141, 150 (2001).

The Plan at issue here requires Montanile "to reimburse the Plan in full for benefits advanced by the Plan" out of "any amounts recovered from another party." J.A. 46. Holding Montanile to that obligation despite his spending the promised fund would preclude him from "overrid[ing] plain contract terms" through what he perceives to be a loophole in the system. *McCutchen*, 133 S. Ct. at 1548. That result is what this Court refused to countenance in *McCutchen*. "Nothing in the statute suggests Congress intended that section 502(a)(3)'s limitation of the [plan's] recovery to 'appropriate equitable relief' would upset the[ ] contractually-defined expectations." *Admin. Comm. of Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan* v. *Shank*, 500 F.3d 834, 839 (8th Cir. 2007). Rather, "if the agreement governs, the agreement governs," and "hewing to the parties' exchange yields 'appropriate' as well as 'equitable' relief." *McCutchen*, 133 S. Ct. at 1547.

b. Allowing an equitable lien by agreement in these circumstances would also further ERISA's "repeatedly emphasized purpose" "to protect contractually defined benefits." *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 148 (1985). A fiduciary is obligated by statute to enforce the Plan by its terms. *See* 29 U.S.C. § 1104(a)(1). And by requiring indi-

vidual beneficiaries to meet their reimbursement commitments under the plan, the fiduciary is honoring its "duty to all beneficiaries to preserve limited plan assets" and "prevent *** windfalls for particular employees." *Conkright*, 559 U.S. at 520 (citing *Varity*, 516 U.S. at 514). As Judge Colloton wrote for the Eighth Circuit, "[r]eimbursement and subrogation provisions are crucial to the financial viability of self-funded ERISA plans, and *** a fiduciary *** must 'preserve assets to satisfy future, as well as present, claims,' and must 'take impartial account of the interests of all beneficiaries.'" *Shank*, 500 F.3d at 838 (quoting *Varity*, 516 U.S. at 514).

3. In arguing to the contrary, both Montanile and the United States ascribe significance to the fact that Congress has not amended Section 502(a)(3) to overrule this Court's prior decisions. They suggest that this legislative inaction should preclude the relief the Plan seeks here. *See* Montanile Br. 46-47; U.S. Br. 28-29. This argument is wrong twice over.

First, there has not been any reason for Congress to act. This Court's precedents permit a Plan to enforce its reimbursement provision through an equitable lien by agreement. And the circuit courts have overwhelmingly held—by a six-to-two margin—that dissipation does not preclude a 502(a)(3) equitable lien by agreement remedy. *See supra* at 8, 13-19.

Indeed, Congress's supposed refusal to amend ERISA Section 502(a)(3) to overrule *Mertens* and *Great-West* is irrelevant precisely because of the Court's later decisions that recognize additional available equitable remedies. *Mertens*, which excluded compensatory relief from Section 502(a)(3)'s reach even though such relief was available under

the common law of trusts, 508 U.S. at 256-257, was followed by *Varity* and *Harris Trust Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000). *Varity* held that employees' breach-of-fiduciary-duty claims seeking individual relief were permissible under Section 502(a)(3) because ERISA was intended to be *more generous* than the common law of trusts. *See* 516 U.S. at 497 ("ERISA's standards and procedural protections partly reflect a congressional determination that the common law of trusts did not offer completely satisfactory protection"). And *Harris Trust* held, unanimously, that participants and beneficiaries could bring Section 502(a)(3) claims against third-party non-fiduciaries for "rescission," "restitution * * * of the purchase price with interest, and disgorgement of * * * profits," 530 U.S. at 243, because Section 502(a)(3) "incorporate[s] common-law remedial principles," *id.* at 252.

The pattern repeated after *Great-West*. After a five-justice majority there held that a plan's assignee could not seek equitable relief through a claim of restitution for unjust enrichment because Great-West had not satisfied the strict restitutionary tracing rules, 534 U.S. at 212-214, a unanimous Court concluded in *Sereboff* that those strict tracing rules were inapplicable to equitable liens by agreement, 547 U.S. at 364-365. As the Court later reiterated in *McCutchen*, "principles of unjust enrichment give way when a court enforces an equitable lien by agreement." 133 S. Ct. at 1547. Neither Montanile nor the United States point to a failed amendment attempt post-dating *Sereboff* or *McCutchen*.

Moreover, in *CIGNA*, 131 S. Ct. 1866, the Court effectively limited *Mertens* and *Great-West* to their facts. It concluded that an injunction requiring a

plan fiduciary to pay money to a beneficiary was an equitable remedy. *Id.* at 1880. In explaining why, the Court likened the plan fiduciary to a trustee and the ERISA plan to a trust, and observed that a suit against a trustee about the trust's terms was historically within the equity courts' exclusive jurisdiction. *Id.* at 1879. The Court then reasoned that "the remedies available to those courts of equity were traditionally considered equitable remedies." *Id.* And it explained that "the fact that this relief takes the form of a money payment does not remove it from the category of traditionally equitable relief." *Id.* at 1880. Indeed, the fact that it was *compensatory* did not either: "Equity courts possessed the power to provide relief in the form of monetary 'compensation' for a loss resulting from a trustee's breach of duty, or to prevent the trustee's unjust enrichment." *Id.*[3]

Second, in any event, the inference that Montanile and the United States ask this Court to draw is an

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[3] Montanile's merits brief (but not his petition) argues that a party may never recover from a participant or beneficiary under ERISA § 502(a)(2). Montanile Br. 19. The United States echoes that argument and further insists that even equitable surcharge against a participant is unavailable in these circumstances because plan participants and beneficiaries do not have "fiduciary obligations." U.S. Br. 20 n.5. These arguments overlook that ERISA defines "fiduciary" to include everyone who "exercises any authority or control respecting management or disposition of [a plan's] assets." 29 U.S.C. § 1002(21)(A)(i). A participant or beneficiary like Montanile fits that definition precisely. *See* J.A. 45 ("[a]mounts that have been recovered by a covered person from another party are assets of the Plan"). The Court therefore should not foreclose the enforcement of reimbursement obligations through Section 502(a)'s other remedies.

unjustifiable one. After all, "unsuccessful attempts at legislation are not the best of guides to legislative intent." *Red Lion Broad. Co.* v. *FCC*, 395 U.S. 367, 381 n.11 (1969); *see also Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 114 (1989) ("failure to act on the proposed bill is not conclusive of Congress' views"). Yet that is the evidence on which Montanile and the United States rely. The Court should reject their calls to attribute to the 1974 enacting Congress the views of later Senators or Representatives.

* * *

Through ERISA, "Congress included various safeguards to preclude abuse and 'to completely secure the rights and expectations brought into being by this landmark reform legislation.'" *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 137 (1990) (quoting S. Rep. No. 93-127, at 36 (1973)). Interpreting Section 502(a)(3) as Montanile requests would do the opposite of "completely secur[ing]" these rights; it would result in just the type of "improbable results" that this Court has eschewed when interpreting ERISA. *Curtiss-Wright*, 514 U.S. at 84. The Court should avoid an improbable result here and adopt the Plan's sensible view of the statute, which has been endorsed by a majority of the courts of appeals.

II. ENFORCING THE PLAN'S LIEN DESPITE MONTANILE'S CLAIMED DISSIPATION IS CONSISTENT WITH HISTORICAL EQUITY PRACTICE.

Enforcing the Plan's equitable lien by agreement is not only consistent with this Court's cases and ERISA's structure and design, but also "the standard current works" and cases from "the days of the divided bench." *Great-West*, 534 U.S. at 212, 217.

A. The Decision Below Is Consistent With Time-Honored Maxims Of Equity.

The foundational maxim of equity is that "'equity suffers not a right to be without a remedy.'" *CIGNA*, 131 S. Ct. at 1879 (quoting Francis, *Maxims of Equity* 29); *see also Miers* v. *Brouse*, 271 S.W.2d 419, 421 (Tex. 1954) (calling this the "first maxim of equity"). The decision below ensures that the Plan's reimbursement right is not left without an enforcement remedy. Montanile and the United States, however, ask the Court to hold the opposite: That *even though* the Plan documents created an equitable lien by agreement over Montanile's tort settlement, and *even though* Montanile had an equitable obligation to turn the settlement over to the Plan, the Plan has no remedy in equity because Montanile broke his promise faster than the Plan sued him for it. Montanile never explains why equity would give the Plan no remedy whatsoever for his breach—because equity courts would not have done so. *Infra* at 29-46.

Another maxim of equity is that "equity looks to intent rather than to form," a principle that "pervades *** the entire system of equity jurisprudence." 2 John Norton Pomeroy, *A Treatise on Equity Jurisprudence* § 378, at 40 (Spencer W. Symons ed., 5th ed. 1941) (1883) (hereinafter, Pomeroy). The decision below did just that. It prioritized Montanile's clearly expressed intent to repay the Plan for the medical expenses it advanced over the formality of tracing rules. And in this way the decision below followed yet another maxim: "equity imputes an intention to fulfill an obligation." *Id.* § 420, at 182. Under this maxim, it "should be presumed that [Montanile] intended to do right, rather than wrong;

to act contentiously, rather than with bad faith; to perform his duty rather than to violate it." *Id.* In other words, the question of the Plan's lien should not be of strict tracing, as Montanile suggests, "but of compelling [Montanile] first to restore the trust property, treating that as something which he had no power to commingle with other funds, but must keep whole and make up so long as he has any funds or property out of which to do so." *City of Lincoln* v. *Morrison*, 90 N.W. 905, 907 (Neb. 1902).

Affording the Plan a remedy, moreover, would not render Section 502(a)(3)'s distinction between legal and equitable remedies superfluous. *Cf.* U.S. Br. 25-26. The maxim that equity suffers not a right without a remedy applies only where "the right *** exists before the equitable remedy [is] invoked." *Sappenfield* v. *Goodman*, 2 S.E.2d 13, 16 (N.C. 1939). A plan would not be permitted to invoke the maxim where the plan documents do not create an equitable lien by agreement or where the beneficiary never receives the pledged fund. *See infra* at 30. But here, the Plan's equitable right to the fund *does* exist, and indisputably so. Applying the maxim therefore simply ensures that Montanile is not better off for having broken his promise instead of keeping it. Denying the Plan a remedy, meanwhile, would contravene the very maxim that is the "source of the entire equitable jurisdiction." 2 Pomeroy § 424, at 185. The Court should reject the illogical and inequitable result Montanile and the United States propose.

B. A Judgment Against General Assets Is Not Necessarily A Legal Remedy.

Montanile's primary argument is that an equitable lien by agreement may be enforced "only against the specifically identifiably property that is the subject of the agreement, or its traceable product." Montanile Br. 30-31. He premises this argument on a simplistic dichotomy: All remedies that operate against a defendant's general assets are legal, while all remedies that operate against specific property are equitable. *See id.* at 35-36. That dichotomy is demonstrably false.

Legal remedies could—and did—operate against specific property. Replevin, for instance, was an action at law to return wrongfully taken, specifically identified property to the plaintiff. 77 C.J.S. *Replevin* § 1; *see also, e.g.*, *General Motors Acceptance Corp.* v. *Vaughn*, 193 N.E. 483, 486 (Ill. 1934); *Vaiden* v. *Bell*, 24 Va. 448, 451 (1825). Similarly, ejectment was a legal suit that allowed the plaintiff to recover possession of particular premises. *E.g.*, *Lundberg* v. *Wolbrink*, 50 N.W.2d 168, 169 (Mich. 1951); *Smith* v. *Robinson*, 13 Ark. 533, 541 (1853).

By the same token, equitable remedies could—and did—operate against a defendant's general assets. Equitable surcharge, for instance, was an equitable remedy allowing a plaintiff to recover from a trustee for breach of his fiduciary duties. 4 Pomeroy § 1080, at 229; George Gleason Bogert, *et al.*, *The Law of Trusts & Trustees* § 862 (hereinafter, Bogert). And this Court has held that an equitable surcharge is available under Section 502(a)(3) *even though* the trustee would be required to pay the judgment out of his general assets; "the fact that this relief takes the

form of a money payment does not remove it from the category of traditionally equitable relief." *CIGNA*, 131 S. Ct. at 1880.

Indeed, for the very equitable remedy at issue here—equitable liens by agreement—courts in the days of the divided bench recognized that "[t]o dedicate property to a particular purpose, to provide that a specified creditor and that creditor alone shall be authorized to seek payment of his debt from the property *or its value*, is unmistakably to create an equitable lien." *Walker*, 165 U.S. at 666 (emphasis added). Thus, not only was the property itself tied up in the equitable lien; its "value" was as well. *See generally* 1 George E. Palmer, *The Law of Restitution* § 2.14, at 176 (1978) (hereinafter, Palmer). That is why, in *Barnes*, the Court upheld an equitable lien by affirming a "decree that Mrs. Barnes was liable to the appellees for $6250." 232 U.S. at 119. That was the value of the promised fund, and that was the amount ordered as a monetary judgment.

C. Possession Of The Identified Fund At The Time Of Suit Is Not A Prerequisite To Enforcement Of An Equitable Lien By Agreement.

Montanile contends that he unilaterally dissolved the Plan's equitable lien by agreement by spending most of the settlement money before the Plan filed suit. Montanile Br. 30-35; *see also* U.S. Br. 18-21. That, too, is incorrect.

1. An equitable lien by agreement arises through "every express executory agreement in writing, whereby the contracting party sufficiently indicates an intention to make some particular property, real or personal, or fund, therein described or identified, a

security for a debt or other obligation." 4 Pomeroy § 1235, at 696. And for agreements secured by property that the promisor does not yet own, the agreement "constitute[s] an equitable lien upon the property *** acquired at a subsequent time." *Id.* § 1236, at 699-700.

Where a promisor agrees that a later-acquired fund will stand as security for his promise, the promisor becomes "a trustee as soon as he gets title to" the fund. *Barnes*, 232 U.S. at 121. In other words, the lien comes into being and "attache[s] not later than" "the moment the fund [i]s received." *Id.* at 121, 122. At that moment, the lien is enforceable. *See, e.g.*, *McColgan* v. *Bank of Cal. Nat'l Ass'n*, 281 P. 381, 385 (Cal. 1929) ("the equitable lien *** attached and became enforceable" at the same time).

These authorities thus confirm that there are three—and only three—elements of an enforceable equitable lien by agreement: (i) a promise to pay money, (ii) out of a specifically identified fund, (iii) that comes into the possession of the defendant. *See Sereboff*, 547 U.S. at 363; *Barnes*, 232 U.S. at 121-123; *see also supra* at 15-17. Once those three elements are met, the plaintiff in equity is "authorized to seek payment" in the form of the fund's "value." *Sereboff*, 547 U.S. at 367-368 (quoting *Walker*, 165 U.S. at 666). No tracing or proof of present possession is required.

2. In arguing the contrary, Montanile relies heavily on treatises emphasizing that an equitable lien typically operates against an identified fund or its traceable proceeds. Montanile Br. 32-33 (discussing 4 Pomeroy §§ 1233-1234 and *Restatement (First) of Restitution* § 161 cmt. c (1937)). But neither of these

sources says that a lienholder has *no* remedy in equity when the identified fund has been dissipated. Other treatises recognized that "occasionally tracing will end in simple money judgment, for example, where the substituted asset cannot be reached because it has been sold or consumed." 1 Palmer § 2.14, at 176. In such cases, "a judgment either *for [the asset's] value* or the proceeds of its sale is the only relief available." *Id.* (emphasis added). Equity courts would not turn a claimant away simply because a defendant had spent the disputed fund after it came into his possession.

Indeed, the Nebraska Supreme Court rejected an argument identical to Montanile's. In *Meier* v. *Meyer*, 43 N.W.2d 502, 504 (Neb. 1950), the defendant induced the plaintiffs to make a loan through fraudulent mortgage notes. The plaintiffs brought suit in equity to reclaim the fund, and the defendant asserted that he "used the money for his own purposes" and "urge[d] that if the plaintiffs may recover at all from him all that recovery must be limited to that portion of the fund which was not used by him and which remained in his bank account after he was notified of the claim of plaintiffs." *Id.* at 505.

Finding the argument "novel and unusual to say the least," the Nebraska Supreme Court disagreed. *Id.* It recognized that "[t]he effect of the [defendant's] contention is to say that funds may come into the hands of a constructive trustee and he may escape liability * * * by dissipating them before notice of a call for an accounting." *Id.* And even though the defendant had "cited in support of the proposition the controlling authorities wherein the purpose is to trace and recover an identifiable fund," the court concluded that "[n]either the authorities cited nor

any others sustained the contention." *Id.* The court therefore required repayment out of the defendant's general funds. *Id.*

Many other equitable cases have likewise recognized that where a promisor has commingled the promised fund with his general assets, the promisee may resort to the entire commingled assets without further tracing. This Court, for instance, has held that where a defendant wrongfully commingles another's property with his own, the true owner may seize the *entire* commingled mass to satisfy his judgment, leaving the wrongdoer to separate out his share. *The Idaho*, 93 U.S. 575, 585-586 (1876). Others have held the same. *Roth* v. *Wells*, 29 N.Y. 471, 491-492 (1864); *Hart* v. *Ten Eyck*, 2 Johns Ch. 62, 108 (N.Y. Ch. 1816), *rev'd on other grounds as reported in*, *Woodcock* v. *Bennett*, 1 Cow. 711, 744 n. a (N.Y. 1823). Thus, the fact that a claimant cannot trace a fund to an independent, segregated account does not render the claimant's cause unenforceable in equity.

3. Montanile's next gambit is to rely on the *Restatement (First) of Restitution* § 215 for his argument that dissipation destroys the Plan's lien. Montanile Br. 34-35. But as its title suggests, the *Restatement of Restitution* focuses on principles governing *restitution*—that is, the principles that govern remedies against "[a] person who has been unjustly enriched at the expense of another." *Restatement (First) of Restitution* § 1.

The equitable lien by agreement is not premised on restitution or unjust enrichment. Dobbs explicitly contrasts the two, noting the equitable lien by agreement in order "to distinguish it from the equi-

table lien imposed by the courts to prevent unjust enrichment." 1 Dan B. Dobbs, *Law of Remedies* § 4.3(3), at 601 (2d ed. 1993) (hereinafter, Dobbs). And so this Court has held that principles governing unjust enrichment are "'beside the point' when parties demand what they bargained for in a valid agreement." *McCutchen*, 133 S. Ct. at 1546 (quoting *Sereboff*, 547 U.S. at 368); *accord Restatement (Third) of Unjust Enrichment & Restitution* § 2(2) (2011). Montanile thus does the very thing that this Court warned against in *McCutchen*: He attempts to apply unjust-enrichment principles to an action that does not sound in unjust enrichment. Montanile's citation to inapposite *Restatement* provisions thus does not support the argument that his dissipation rendered the Plan's equitable lien by agreement unenforceable.

In any event, the *Restatement* provision that Montanile cites describes a rule of creditor priority, rather than lien enforceability. *See Restatement (Third) of Unjust Enrichment & Restitution* § 60(3) (rule under heading of "Priority"); *id.* par. tbl. (explaining that former *Restatement (First) of Restitution* § 215(1) is now *Restatement (Third) of Unjust Enrichment and Restitution* § 60(3)). The Plan is not seeking priority over any of Montanile's other creditors, *see infra* at 35, so Montanile's supposedly on-point precedent has no bearing on this case.

4. In the end, Montanile's argument fails for an entirely practical reason: Equity recognizes that money is fungible. Even if a plaintiff's money cannot be traced to the purchase of a particular product, the defendant's overall assets have been augmented from the defendant's possession of the plaintiff's money. The wrongdoer was able to use the plaintiff's mon-

ey—rather than his own—to pay for his purchases. In that way, the wrongdoer's general assets are a product of the plaintiff's wrongfully taken funds. *See* Kingsley A. Taft, Note, *A Defense of a Limited Use of the Swollen Assets Theory Where Money Has Been Wrongfully Mingled With Other Money*, 39 Colum. L. Rev. 172, 180-182 (1939).

Consistent with this insight, numerous courts held that plaintiffs could recover their money from defendants without identifying the funds in the defendants' hands or an identifiable product.[4] Courts adopting this "swollen-assets doctrine" sensibly concluded that recovery is permitted even where—like Montanile—the defendant claimed that the plaintiff's funds were traceable to assets in the hands of a third party. *Word* v. *Sparks*, 82 S.W.2d 5, 8

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[4] *See Squire* v. *American Express Co.*, 2 N.E.2d 766, 257-258 (Ohio 1936) ("It is not necessary to be able to identify the particular money deposited nor to show that the amount purported to have been received was converted into specific cash, when such amount is commingled with general funds of the bank. This is the rule prevailing in most jurisdictions.") (citations omitted); *First Trust Co. of Lincoln* v. *Exchange Bank*, 254 N.W. 569, 575 (Neb. 1934) ("The trust fund having been mingled with the general mass of bank assets which were thus augmented and enhanced, resort may be had in equity to impress thereon a preferred claim payable from such general mass of bank assets."); *Eastman* v. *Farmers' State Bank of Olivia*, 221 N.W. 236, 237 (Minn. 1928) ("The burden of proof goes no farther than to require plaintiffs to show that the money actually came into the hands of the bank."); *Orr* v. *St. Louis Union Trust Co.*, 236 S.W. 642, 649 (Mo. 1921) ("We are persuaded that, as to such part of her trust funds as were mingled with testator's general property, and cannot now be traced, his entire estate is liable * * *."), *overruled on other grounds by*, *State* v. *Cross*, 366 S.W.2d 434 (Mo. 1963).

(Ark. 1935). The traced assets, the court explained, "greatly enhanced" the defendant's other holdings "and necessarily swelled them." *Id.* As a result, the "trust funds were not dissipated or wasted, but are still part of the assets of the [defendant]." *Id.* Under this equity precedent, all the Plan had to prove was that its promised settlement funds were once in Montanile's possession, a fact Montanile conceded. J.A. 25.

Courts at equity sometimes declined to adopt the swollen-asset doctrine in cases where the defendant was insolvent because it gave the plaintiff's claim priority over that of the defendant's general creditors. *See, e.g., Nonotuck Silk Co.* v. *Flanders*, 58 N.W. 383, 385-386 (Wis. 1894); *Slater* v. *Oriental Mills*, 27 A. 443, 443-444 (R.I. 1893). That concern is not implicated here. Montanile is not insolvent; the Plan is not seeking priority over anyone else; and there is no need to determine whether the Plan would have priority if were seeking such status in a hypothetical bankruptcy proceeding. The Plan simply seeks a declaration that it has a valid lien against Montanile's assets. Montanile's ability to satisfy the Plan's judgment is a matter to be addressed when the Plan pursues enforcement, not before.

In short, the swollen-assets doctrine prevents the fiction of strict tracing from trumping the reality of money's fungibility. *See* 2 Dobbs § 6.1(3), at 15 ("If the swollen assets approach only operated to redress a wrong to the plaintiff, that approach would be accepted without dispute."); Taft, *supra*, at 189 ("[p]erhaps the formalism of the 'strict tracing' theory may be justified to protect general creditors * * * but certainly that formalism should not be

applied as to negative use of the 'swollen assets' theory, where substantial justice requires it"); Varro H. Rhodes, Comment, *Trusts—Tracing of Assets—Preference*, 30 Mich. L. Rev. 441, 451 (1931) (calling the swollen-assets doctrine "morally and practically justified" where it "does not leave the general creditor in a worse position"). This doctrine, from the days of the divided bench, fully supports the result reached below. Allowing the Plan's lien without regard for tracing is therefore perfectly consistent with historical equity jurisprudence.[5]

D. The Plan Is Also Entitled In Equity To A Substitutionary Monetary Decree Or Deficiency Judgment.

Even if Montanile's asserted dissipation destroyed the Plan's equitable lien—and it did not—the Plan would still be entitled to a substitutionary monetary decree or deficiency judgment. Such remedies were traditionally available in equity when a lien was no longer enforceable or the pledged fund was insufficient to satisfy the promisor's obligations.

1. a. A substitutionary monetary decree was available in equity when a promisor had dissipated or destroyed property to which a lien had attached.

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[5] To be sure, tracing remains an important tool for plans in many respects. Tracing allows a plan to recover plan assets from transferees who accepted them despite knowing of a plan's lien or who gave no consideration for the transfer. 2 Dobbs § 6.1(2), at 7. Tracing also allows the plan to secure a first-priority lien on property purchased with the plan's assets. Bogert § 862. But these are simply practical benefits of a plan being able to trace; tracing is not a prerequisite to an enforceable equitable lien by agreement.

Writing for the Massachusetts Supreme Judicial Court, Justice Holmes explained that where a plaintiff's complaint seeks "the recovery of an identified fund, wherever it may be found," the plaintiff's claims do not fail simply because "the fund is gone, and has been misappropriated by *** the defendants." *Otis* v. *Otis*, 45 N.E. 737, 737 (Mass. 1897). Rather, "[u]nder these circumstances, the plaintiff has a right to compensation as alternate relief, and is entitled to a decree against all the parties concerned." *Id.* Justice Story gave another example of this remedy: "if, pending a suit for specific performance of an agreement for a demise of quarries, a part of the subject-matter of the demise is abstracted, compensation may be obtained therefor by a supplemental bill." 2 Joseph Story, *Commentaries on Equity Jurisprudence as Administered in England & America* § 794, at 2 (Isaac F. Redfield ed. 10th ed. 1870) (hereinafter, Story); *see also id.* § 798, at 7 (a substitutionary monetary decree is available in equity where vendor of land wrongfully transferred property to bona fide purchaser without notice).[6]

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[6] *See also Sargent* v. *Wood*, 81 N.E. 901, 902 (Mass. 1907) (recognizing the "right to compensation as alternate relief"); *Federal Trust Co.* v. *Baxter*, 257 N.W. 368, 370 (Neb. 1934) (a monetary decree for the value of property alienated through its transfer to an innocent purchaser was available "as a substitute" for the transferred property); *Shafer's Appeal*, 110 Pa. 382, 386-387 (Pa. 1885) (acknowledging a procedure whereby "[w]hen the defendant has put it out of his power to perform [a] contract, the bill will be retained, and it will be referred to a master to assess the damages"); *Woodcock* v. *Bennett*, 1 Cow. 711, 755 (N.Y. 1823) (same).

b. Contrary to the United States' claims (Br. 24), these substitutionary monetary decrees were equitable remedies. The Massachusetts Supreme Judicial Court, for instance, repeatedly held that "[o]rdinarily a proceeding to enforce * * * a constructive trust or equitable lien, or in the alternative, to obtain compensation for the wrongful use of property subject to such a trust or lien, is within the scope of general equity jurisdiction." *Locke* v. *Old Colony Trust Co.*, 193 N.E. 892, 895 (Mass. 1935); *see also Jones* v. *Jones*, 7 N.E.2d 1015, 1018 (Mass. 1937) ("And if money so received is not traceable into specific property, alternative relief by compensation for wrongful use of the money is within such jurisdiction."). The Arkansas Supreme Court, too, has held the remedy against a promisor who has destroyed a lien is "a suit in equity." *Bank of Marion* v. *Beck*, 136 S.W.2d 188, 189 (Ark. 1940). Such a suit, Justice Story observed, was an exception, based on the "peculiar equity" of the circumstances, to the general rule that the equity courts did not award damages. 2 Story § 794, at 2.

As a result, courts sitting in equity *rejected* arguments like the United States' that a claimant had to go to the law courts to recover on a dissipated or destroyed lien. New York has several such examples. *See Woodcock*, 1 Cow. at 755; *Wiswall* v.

McGowan, Hoff. Ch. 125, 133 (N.Y. Ch. 1839).[7] And the Alabama courts held such an action was not, as the United States contends (Br. 24), an action at law for trover. *Clark* v. *Johnson & Latimer*, 61 So. 34, 36 (Ala. App. 1913). Substitutionary monetary decrees, in short, were awardable in equity as equitable remedies, not legal ones.

2. a. Plaintiffs like the Plan also had resort to a deficiency judgment when insufficient value remained in a pledged fund to satisfy the promisor's obligation. In equity, the lien functioned as a "charge or hypothecation" on the promised fund, akin to a mortgage. 4 Pomeroy § 1234, at 695. The traditional way to levy on the lien was to foreclose it, obtaining a judicial decree that the fund should be sold and the proceeds transferred to the plaintiff. *Id.* § 1228, at 681-682.

At times, the sale of the fund would not be sufficient to satisfy the plaintiff's lien. In such cases, "the plaintiff is allowed * * * a personal judgment for the amount of the deficiency, without further suit." *Id.* § 1228, at 683; *see also* 1 Palmer § 1.5, at 20 (recognizing that in some cases an "equitable lien may be more advantageous because the plaintiff has a money claim to the extent not satisfied through enforcement of the lien"). Nor was the deficiency judgment an all-or-nothing proposition. A plaintiff

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[7] Respondent and the United States both rely on New York law, for seemingly contradictory propositions. The United States cites *Hovey* v. *Elliott*, 23 N.E. 475, 478 (N.Y. 1890), as providing that an action on a dissipated lien is an action at law. U.S. Br. 24, 33. But *Hovey* discussed actions at law in relation to the applicable statute of limitations only; it did not purport to resolve the law-equity question. *See* 23 N.E. at 142.

could obtain "an equitable lien on the property coupled with a money judgment," a procedure Dobbs explains was equivalent to "a constructive trust with a money judgment for any deficiency in value." 1 Dobbs § 4.3(3), at 602 & n.6. In this way, the "[d]ifferent forms of relief can be combined so as to assure the victim of the wrong the full recovery to which he is entitled." 1 Palmer § 2.14, at 176.

b. Montanile and the United States nonetheless argue that although a deficiency judgment was available in equity, it was legal in nature. Montanile Br. 37-39; U.S. Br. 21-24. Both misunderstand the history of the remedy and its role in equity practice.

At one time, this Court had held that federal courts could not enter deficiency judgments absent a statute or court rule because chancery courts in England could not do so. *See Orchard* v. *Hughes*, 68 U.S. 73, 77 (1863); *Noonan* v. *Lee*, 67 U.S. 499, 509 (1862). But the Court also recognized the injustice of that result, and it promptly issued Equity Rule 92 in April 1864—later renumbered as Equity Rule 10—to address it. *See White* v. *Ewing*, 69 F. 451, 454 (6th Cir. 1895) (noting Rule 92's adoption); *Lane* v. *Equitable Trust Co. of N.Y.*, 262 F. 918 (C.C.A. 8th 1919) (noting Rule 92's renumbering). Under the Rule, "[i]n suits for the foreclosure of mortgages, or for the enforcement of other liens, a decree [could] be rendered for any balance found to be due to the plaintiff over and above the proceeds of the sales" of the property that was subject to the lien and "execution [could] issue for the collection of the same" out of the defendant's general assets. Fed. Equity R. 10 (1912).

Far from proving that deficiency judgments were unavailable in equity, the Court's actions reflect the

equity system's flexibility. Equity's original purpose was to free litigants from the overly rigid remedies and forms of action available in the law courts—that is, to shift traditionally legal relief into the realm of equity. Equity's genius was in "its power to enlarge the scope of these ordinary forms of relief, and even to contrive new ones adapted to new circumstances, *** with its unlimited control over the form and material of its judgments," which provided "enormous advantages over the narrow, inflexible, and artificial methods of the common law." 1 Pomeroy § 116, at 155-156.

Montanile and the United States' argument appears to be that the "appropriate equitable relief" available under Section 502(a)(3) is not just limited to those remedies that were available in the days of the divided bench, but those remedies that were available in the *earliest* days of the divided bench. But *Mertens* contains no such limitation. It held that Section 502(a)(3) authorizes all of the remedies that were "*typically* available" in the days of the divided bench. 508 U.S. at 256. The end point for the days of the divided bench, at least in the federal system, is September 16, 1938, with the creation of "one form of action—the civil action." Fed. R. Civ. P. 2 (1938). At that time—and for a number of decades leading up to that time—the deficiency judgment was typically available in the equity courts.

Montanile and the United States' rule is also unworkable. They do not say *when* the historic equity law embraced by Section 502(a)(3) cuts off. Is the cut off English chancery practice at the time of Independence? The promulgation of the first Judiciary Act? Some later time? *Cf. Mertens*, 508 U.S. at 257 n.7 (indicating that "equitable relief" should be

interpreted to "correspond to the state of the law when ERISA was enacted"). Montanile and the United States do not offer answers. Yet, for an inquiry focused on historic equity practice, it is hard to think of a more helpful guide than the historic rules this Court promulgated to govern equity practice.

3. Montanile and the United States also argue that substitutionary monetary decrees and deficiency judgments are not equitable remedies, but instead are simply part of equity courts' ancillary or "clean up" legal jurisdiction. *See* Montanile Br. 37-39; U.S. Br. 21-25. Not so.

Both Montanile and the United States overlook *CIGNA*, where this Court provided a generalized inquiry for determining whether a remedy is "appropriate equitable relief": Is the remedy the plaintiff seeks under Section 502(a)(3) "'exclusively equitable'"? 131 S. Ct. at 1880 (citation omitted). For the substitutionary-monetary-decree and deficiency-judgment remedies the Plan seeks here, the answer to that question is yes.

Substitutionary monetary decrees and deficiency judgments are exclusively equitable because they flow directly from equity's jurisdiction over equitable-lien claims. As noted, an action to establish and enforce an equitable lien is equivalent to an action to foreclose on the lien, and "all matters pertaining to the foreclosure of a mortgage are inherently of equitable jurisdiction," including "proceedings instituted, as in this case, for relief against fraud." *McCormick* v. *Hartley*, 6 N.E. 357, 359 (Ind. 1886); *see also Lembeck & Betz Eagle Brewing Co.* v. *Sexton*, 184 N.Y. 185, 190 (1906) ("[a]n action in equity to fore-

close a chattel mortgage * * * is doubtless a remedy which a mortgagee may properly invoke"). As in *CIGNA*, the substitutionary monetary decree and deficiency judgment the Plan seeks are exclusively equitable and thus available under Section 502(a)(3).

In addition, Pomeroy confirms that substitution monetary decrees and deficiency judgments were, as a class, typically and exclusively available in equity. He dedicates an entire chapter of his equity treatise to "remedies in which the final relief is pecuniary, but is obtained by the enforcement of a lien or charge upon some specific property or fund." 4 Pomeroy § 1413, at 1061 (capitalization altered). He explains that these classes of remedies, including "suits to enforce the various equitable liens," are "*all purely equitable, and therefore belong to the exclusive jurisdiction*" of the equity courts, even though "the *final* relief is pecuniary and so resembles the ordinary relief at law." *Id.* (first emphasis added). That is because the remedy is "obtained through preliminary proceedings, forming a part of the judgment, which belong solely to the procedure and jurisdiction of equity." *Id.* Pomeroy further contrasts these exclusively equitable remedies with another group, "in which the final relief is wholly pecuniary and is obtained in the form of a general pecuniary recovery." *Id.* § 1416, at 1070 (capitalization altered); *compare also id.* § 146, at 198 (listing those remedies in "the exclusive jurisdiction" of equity, including "equitable liens") (capitalization altered), *with id.* § 174, at 235-236 (listing those remedies that belong to the concurrent jurisdictions of law and equity, which do not include equitable liens). Pomeroy thus confirms that substitutionary monetary decrees and deficiency judgments were both "typically," *Mertens*,

508 U.S. at 256, and "'exclusively,'" *CIGNA*, 131 S. Ct. at 1880 (citation omitted), available in equity at the time of the divided bench.

4. Montanile's and the United States' fallback position is that if the Court concludes that a substitutionary monetary decree or deficiency judgment is appropriate, a remand is necessary to determine their availability in this case. Montanile Br. 39-42; U.S. Br. 32-34. It is not.

As for a substitutionary monetary decree, the United States argues that the Plan must show that Montanile dissipated his settlement with knowledge of the Plan's claim and with the intent to deprive the Plan of its recovery. U.S. Br. 33-34. Wrong. For the equitable remedy recognized in *Otis* and other cases, all the Plan must show is that its fund has been "misappropriated" through Montanile's actions. *Otis*, 45 N.E. at 737. And it has.[8]

But even if the United States' knowledge and intent requirements were the law, the Plan proved both of them. Montanile knew of the Plan's claim many times over, yet spent the Plan's money anyway. *See* J.A. 24-25 (attorney's attempts to negotiate claim on Montanile's behalf); J.A. 35 (constructive knowledge from Plan documents); J.A. 51 (acknowl-

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[8] The United States erroneously assumes a claim for a substitutionary monetary decree is an action at law for trover. *Supra* at 39. Even for such actions, however, there is no *mens rea* requirement. *See* 90 C.J.S. *Trover and Conversion* § 8 ("[I]t is not essential to conversion that the motive or intent with which the act was committed have been wrongful, corrupt, or bad.") (footnotes omitted).

edgement form); J.A. 76 (Montanile's admission that he spent "[m]ost" of the Plan's money).

The same is true for a deficiency award. The United States says that the Plan should be required to show that Montanile "still possesses a portion of his recovery." U.S. Br. 33. But Montanile admitted that below. He conceded at the summary-judgment stage that he still possessed a "small portion of the proceeds realized from the settlement of his claims." J.A. 57. That is enough, even under the United States' view, for a deficiency judgment to be proper.[9]

Perhaps aware of these flaws, Montanile claims that a deficiency judgment would be improper because the Plan took too long to bring its suit. Montanile Br. 39-42. But Montanile raised a laches claim below, the District Court rejected it, and Montanile did not press it on appeal. *See* Pet. App. 34a; Montanile C.A. Br. 15-36. He cannot reraise it again in this Court under the guise of resisting a deficiency judgment. *See Adickes* v. *SH Kress & Co.*, 398 U.S. 144, 147 n.2 (1970) ("Where issues are neither raised before nor considered by the Court of Appeals, this Court will not ordinarily consider them."). If the Court concludes a substitutionary monetary decree or a deficiency judgment is proper,

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[9] Montanile and the United States point out that the Plan did not explicitly request a substitutionary monetary decree or deficiency judgment in its pleadings. Montanile Br. 37; U.S. Br. 32. But that is of no moment, because under both modern and historic practice, a request for an equitable lien encompasses a request for a substitutionary monetary decree and a deficiency judgment. *See* Fed. R. Civ. P. 54(c); *Otis*, 45 N.E. at 737.

all it need do is affirm the Eleventh Circuit's judgment.

III. ACCEPTING MONTANILE'S VIEW WOULD GREATLY INCREASE THE BURDENS ON PLANS AND THE COURTS.

The decision below is consistent with ERISA's text, this Court's caselaw, and traditional equitable practice. But most of all, it makes good sense. This Court has repeatedly emphasized Congress' goal of ensuring that ERISA plans are administered and enforced according to their terms. Montanile, however, asks this Court to "interject other additional issues into ERISA litigation," *Conkright*, 559 U.S. 519, by requiring a plan fiduciary to trace the present location of the promised fund every time it wants to enforce the plan's reimbursement provision. That requirement would burden beneficiaries, plans, and courts alike. It is the antithesis of "ERISA's objective of efficient plan administration," *Egelhoff*, 532 U.S. at 149 n.3, and should be rejected.

A. Montanile's Approach Will Discourage Employers From Offering Benefits And Will Lead To Higher Premiums.

1. Montanile and his *amici* try to minimize the negative effects that their approach would have on ERISA plans. But there can be no serious dispute about the impact. Any hurdle to efficient plan administration "might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 11 (1987). That possibility is enough to avoid a result that "could work to the detriment of plan beneficiaries." *Ingersoll-Rand*, 498 U.S. at 142.

Montanile invites just that result here, by limiting plans' ability to recover reimbursements from beneficiaries. Estimates suggest that plans recover a significant sum—more than $1 billion annually—under reimbursement provisions. *See Sereboff* Br. of *Amicus Curiae* America's Health Ins. Plans, Inc. *et al.* in Support of Respondent, 2006 WL 460877, at *3 n.3. That is why so many authorities have recognized that "[r]eimbursement and subrogation provisions are crucial to the financial viability of self-funded ERISA plans." *Shank*, 500 F.3d at 838; *accord Zurich Am. Ins. Co.* v. *O'Hara*, 604 F.3d 1232, 1238 (11th Cir. 2010). Even critics of plan reimbursement rights admit that reimbursement protects plan solvency: "[A]n insuring entity *** that receives substantial subrogated recoveries into its coffer will be financially healthier than one that lacks those recoveries." R.M. Baron, *Public Policy Considerations Warranting Denial Of Reimbursement to ERISA Plans: It's Time to Recognize The Elephant In The Courtroom*, 55 Mercer L. Rev. 595, 630 (2004). "Reimbursement inures to the benefit of all participants and beneficiaries by reducing the total cost of the Plan." *O'Hara*, 604 F.3d at 1237-1238.

The rule Montanile advocates—barring reimbursement where a beneficiary has spent down the promised fund—will *reduce* reimbursement recoveries and *increase* plan costs. Even a small increase in plan costs has potentially serious adverse effects: "[E]ach one percent increase in managed care plans' costs *** results in a potential loss of insurance coverage for about 315,000 individuals." Health Economics Practice, Barents Group, LLC, *Impacts of*

Four Legislative Provisions on Managed Care Consumers: 1999-2003, at iii (1998).

2. Limiting plans' ability to enforce reimbursement provisions by permitting beneficiaries' dissipation will also likely raise premiums—a fact Montanile's *amici* dispute, but one that is both well-accepted and obvious. Insurers set premiums by projecting future expected losses. *See* Gary Wickert, *ERISA and Health Insurance Subrogation* § 1.04, at 1-39 (5th ed. 2013). Higher reimbursement rates drive down expected losses. *See id.* Conversely, each dollar the plan fails to recover results in a smaller pool of funds for beneficiaries. *McCutchen* Br. of *Amicus Curiae* Blue Cross Blue Shield Ass'n *et al.* in Support of Petitioner, 2012 WL 3875234, at *12. So if Montanile (or any beneficiary) "were relieved of his obligation to reimburse [the plan] for the medical benefits it paid on his behalf, the cost of those benefits would be defrayed by other plan members and beneficiaries in the form of higher premium payments." *O'Hara*, 604 F.3d at 1238. In other words, all of the Plan's other beneficiaries would have to chip in to cover the $120,000-plus windfall that Montanile—and any other similar beneficiary—would receive by having the Plan pay for his medical expenses and spending the tort settlement funds meant to repay those expenses on other things.

B. The Other Remedies Supposedly Available To Plans Are Inefficient And Unreliable.

Montanile and his *amici* tell the Court that adopting their position is unlikely to change the status quo because there are alternative mechanisms for plans to enforce reimbursement provisions. *See, e.g.*, Montanile Br. 44-45; U.S. Br. 29-31. But the only

alternatives Montanile and his supporters offer are costly and uncertain; they fail to ensure that plans will recover the amounts owed.

1. Montanile would put the onus on the plans to hunt down funds after beneficiaries improperly spend them and essentially create an accounting of what the beneficiary purchased with them. Montanile Br. 44-45. This encourages gamesmanship of the worst kind; it would convert ERISA into a game of cat-and-mouse that rewards deceptive individual beneficiaries at the expense of all beneficiaries.

As this case demonstrates, even when participants are fully aware of their reimbursement obligation, they will often avoid complying with it and set up roadblocks to try to prevent plans from being able to enforce the obligation. Montanile challenged the Plan's ability to seek reimbursement of any kind under the plan documents, despite signing a separate acknowledgement in which he clearly promised to reimburse the Plan. J.A. 50-51. He also claimed that he did not have to reimburse the Plan until it met a non-existent requirement to prove compliance with ERISA's anti-inurement provision. *See* Pet. App. 34a. In other words, there was no dispute that Montanile had agreed to reimburse the Plan; the only question was whether Montanile could find some legal loophole barring the Plan from enforcing his agreement.

This pattern repeats again and again in ERISA reimbursement cases. Before this Court ruled in *McCutchen* that beneficiaries could not use unjust-enrichment defenses to defeat plan reimbursement provisions, beneficiaries commonly argued that plans were entitled to reimbursement only out of the

portion of a tort settlement that was allocated to the payment of medical expenses, which was often, unsurprisingly, very little. As the United States recognized in its brief in *Sereboff*: "[T]he full reimbursement provision avoids the potential for strategic behavior in structuring a settlement by the insured and tortfeasor, who generally will have little reason to resist classifying damages as flowing from something other than medical costs." *Sereboff* U.S. Br., 2006 WL 460876, at *30 n.15.

Dissipation is simply the latest in this long line of avoidance tactics. Montanile would require plans to prove in every case that the beneficiary had actual and present possession of the fund that the defendant promised to repay. And if the fund had been used to purchase an asset, the plan would have to prove that fact. The resources required to resolve these factual inquiries would not just cut down on reimbursements and make administration less predictable; they also would dramatically increase the litigation burden on plans and courts alike.

This Court already has rejected interpretations of ERISA that have that effect. The Court explained in *Conkright*, for example, that ERISA "encourag[es] resolution of benefits disputes through internal administrative proceedings rather than costly litigation." 559 U.S. at 517; *accord FMC*, 498 U.S. at 65 (ERISA is designed to "avoid 'endless litigation,'" not to multiply it) (quoting 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits)). For that reason, the Court reversed a decision that had the effect of "interject[ing] other additional issues into ERISA litigation," thereby "increas[ing] litigation costs." *Conkright*, 559 U.S. at 518-519.

Montanile's present-possession rule has all of the ills that the Court criticized in *Conkright* and like cases. His approach would "further complicate ERISA proceedings." *Id.* at 519. It " 'would undermine the congressional goal of minimizing the administrative and financial burdens on plan administrators—burdens ultimately borne by the beneficiaries.' " *Egelhoff*, 532 U.S. at 150-151 (quoting *Ingersoll-Rand*, 498 U.S. at 142). And it would "unduly discourage employers from offering ERISA plans in the first place." *Conkright*, 559 U.S. at 517 (quoting *Varity*, 516 U.S. at 497).

2. Montanile's next supposed solution is for plans to seek preliminary injunctions against beneficiaries as a matter of course as soon as the beneficiary receives the funds from a tort settlement. Montanile Br. 3, 22 n.13. But plans often do not know when a case will settle, when funds will be disbursed to the beneficiary, whether the beneficiary will honor his reimbursement obligation, and how quickly the beneficiary will spend the money on things other than repaying the plan. Montanile's proposal overlooks, among other things, the narrowness of the window of time available to a plan to make such a filing. If the plan acts too soon, the case is not yet ripe. *See generally City of Los Angeles* v. *Lyons*, 461 U.S. 95, 102 (1983) (to satisfy Article III's case-or-controversy requirement, the plaintiff's "injury or threat of injury must be both 'real and immediate,' and not 'conjectural' or 'hypothetical' "). If the plan acts too late, the funds will have been dissipated—as they were here. *See* J.A. 57.

Even assuming the plan succeeds in filing an emergency motion in that narrow sliver of time, "[a] preliminary injunction is an extraordinary remedy

never awarded as of right." *Winter* v. *NRDC*, 555 U.S. 7, 24 (2008). There is no guarantee that a court will award the plan such a drastic remedy even when dissipation of the promised fund is imminent. *See Great-West*, 534 U.S. at 208 (district court denied Great-West's motions for a temporary restraining order and preliminary injunction). Nor is there any guarantee that a court will grant the relief in a timely manner. *See Central States, Se. & Sw. Areas Health & Welfare Fund* v. *Lewis*, 745 F.3d 283, 288 (7th Cir. 2014) ("The preliminary injunction was not issued until ten months after the suit had been filed[.]").

In response, both Montanile and the United States suggest that the fund need be in the defendant's possession only when the case is filed. *See* Montanile Br. i; U.S. Br. 7. But they cite no authority to support their line drawing. If a court can award an equitable lien by agreement only if the promised fund is *presently* in the defendant's hands, then presumably the fund must be in the defendant's possession when judgment is rendered. Indeed, that is the only way Montanile's argument makes any sense because, in this case, he admitted to possessing the funds in his answer, and then only later, at summary judgment, did he deny possession. *Compare* Compl. ¶ 15 (Dkt. No. 1) ("all or part of the settlement proceeds are within the actual or constructive possession of Defendant Montanile"), *and* Answer ¶ 15 (Dkt. No. 11) (admitting same), *with* J.A. 57 ("Montanile denies that he is in actual or constructive possession of any but a small portion of the proceeds realized from the settlement of his claims."). So even if a plan does everything that Montanile says it is supposed to do—that is, move

immediately for injunctive relief—the plan *still* may not recover the promised fund if the beneficiary dissipates the fund before final judgment.

3. Montanile and the United States also contend that the rules of professional responsibility governing attorney conduct suffice to ensure settlement funds are not prematurely dissipated. Montanile Br. 42-44; U.S. Br. 31. They assume, of course, that beneficiaries always inform their tort-suit lawyers about any reimbursement obligation. And they assume that the professional rules in fact bar a lawyer from dissipating the fund. But the answer is not so clear.

Montanile declares without citation that "tort settlements are typically released to and spent by an injured ERISA participant only after the plan has been notified that the lien (or its amount) is disputed and then fails to act." Montanile Br. 43. But not all states require an attorney to notify third-party creditors of a settlement prior to distribution of the fund to the beneficiary-client. In fact, Connecticut *forbids* such pre-distribution notification. *See Silver* v. *Statewide Grievance Comm.*, 1995 WL 416270, at *2-*4 (Conn. Super. Ct. Jul. 6, 1995), *aff'd*, 679 A.2d 392 (Conn. Ct. App. 1996). And even where an attorney is permitted or obligated to provide notice to potentially interested third-parties, the ethical rules are not uniform about an attorney's obligation to withhold funds from the client. Courts have offered "[w]idely disparate answers" on the question, with some holding that "a lawyer has no duty to a client's third party creditors and is required to follow a client's instructions even if the instructions violate the terms of an assignment agreement between the client and the creditor." M. Colette Gibbons & Elin

Brenner, Am. Bar Ass'n, *Divided Loyalties: A Lawyer's Duties to A Client's Creditors*, 10 Prob. & Prop., Dec. 1996, at 24. In the District of Columbia, for example, a lawyer may withhold funds arising out of a client's contractual obligation to pay *only if* the agreement is "joined in or ratified by the lawyer." D.C. Ethics Opinion 293 (Feb. 2000), https://goo.gl/m2BHw8. And where the attorney is found to violate her ethical obligations, bar discipline does not necessarily result in repayment of the fund.

Past experience bears out the inadequacy of the rules of professional conduct to avoid dissipation. Although Montanile asserts (again without citation) that "[p]ersonal injury attorneys virtually never release funds without first giving the plan an opportunity to act," Montanile Br. 42, the caselaw shows otherwise. Attorneys time and again have proven either unwilling to abide by their ethical obligations or at least willing to stretch the limits of those obligations to the breaking point. *See, e.g.*, Pet. App. 47a (*Elem*) (beneficiary "and her attorney conspired to hide and disburse settlement funds"); *Central States*, 745 F.3d at 285, 287 (beneficiary's attorney "refus[ed] to honor the subrogation lien" and "willfully ignored the plan's lien against the settlement proceeds"); *ACS Recovery Servs., Inc.* v. *Griffin*, 723 F.3d 518, 521 (5th Cir. 2013) (en banc) ("Rather than help [the beneficiary] comply with the Plan, his attorney devised an artful attempt to insulate the settlement proceeds from the reimbursement provision."). Neither Montanile nor his *amici* offer any way to stop these bad-faith actors—yet another reason to reject their approach.

Beneficiaries, moreover, do not need Montanile's self-help dissipation solution to protect themselves

from plans that sleep on their rights. The traditional, equitable affirmative defense of laches protects defendants from "unreasonable delay by [a] plaintiff in prosecuting a claim or protecting a right of which the plaintiff knew or should have known, and under circumstances causing prejudice to the defendant." 1 Dobbs § 2.4(4), at 103. And courts routinely evaluate the defense in ERISA reimbursement cases, as the District Court did below. *See* Pet. App. 34a; *see also, e.g.*, *Bd. of Trustees of the Nat'l Elevator Indus. Health Benefit Plan* v. *McLaughlin*, No. 12-4322, 2014 WL 284431, at *4 (D.N.J. Jan. 24, 2014) (considering and rejecting a laches defense to a plan's reimbursement claim); *Anderson* v. *First Unum Life Ins. Co. of Am.*, No. 5:12–CV–00208–SWW, 2014 WL 130490, at *3 (E.D. Ark. Jan. 14, 2014) (same). That Montanile's laches defense was not successful on his particular facts is no reason to adopt his spend-the-fund remedy in all cases.

4. Montanile's final contention is that the Plan could have simply exercised its right to subrogation or intervened in Montanile's tort lawsuit to protect its reimbursement interests. Montanile Br. 45; *see also* U.S. Br. 30. But that is not the bargain Montanile struck with the Plan. The Plan "has a right to first reimbursement out of any recovery," and "[a]cceptance of benefits from the Plan * * * constitutes the covered person's agreement to file a claim for benefits against any party who is liable for the injury or illness to the covered person." J.A. 46. Montanile cannot after-the-fact renege on that agreement by arguing that the Plan had other options available to it.

Moreover, the other-options argument works both ways. Montanile, too, had other options available to

him if he wanted to challenge the validity of his reimbursement obligation. For example, he could have sued the Plan under ERISA Section 502(a)(1)(B) "to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." Or he could have sued under Section 502(a)(3)(A) "to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan." Either path would have allowed him to test whether the Plan documents, in fact, created a reimbursement obligation. The Plan, which had already fulfilled its end of the bargain, should not be the one saddled with bringing litigation to ensure that Montanile fulfills his end, too.

5. At bottom, Montanile's position boils down to the proposition that the actions of beneficiaries can trump the terms of a plan and void a reimbursement obligation. *See* Pet. App. 34a. Beneficiaries can cut off a plan's equitable remedy by simply spending the settlement fund on whatever they may choose, and the plan's equitable remedy will therefore remain available only so long as the beneficiary does not spend the plan's money.

As the Court held in *Varity*, "[w]e are not aware of any ERISA-related purpose that denial of a remedy would serve. Rather, we believe that granting a remedy is consistent with the literal language of the statute, the Act's purposes, and pre-existing trust law." 516 U.S. at 515. The Court should reach the same holding here. An ERISA plan may enforce an equitable lien by agreement as soon as a promised fund reaches the beneficiary's hands, and the beneficiary's subsequent dissipation of that fund does not defeat the plan's claim.

CONCLUSION

The judgment of the court of appeals should be affirmed.

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ADDENDUM

ERISA § 502, 29 U.S.C. § 1132, provides in pertinent part:

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

* * * *

Supreme Court, U.S.
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No. 14-723

IN THE
Supreme Court of the United States

ROBERT MONTANILE,
Petitioner,
v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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QUESTION PRESENTED

Whether a beneficiary of a benefit plan governed by the Employee Retirement and Income Security Act of 1974 can defeat enforcement of the plan's valid equitable lien by agreement—after the lien attaches—by dissipating the fund subject to the lien.

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IN THE

Supreme Court of the United States

No. 14-723

ROBERT MONTANILE,

Petitioner,

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF FOR RESPONDENT

INTRODUCTION

This case raises an important question of federal law that has divided the courts of appeals: Can a beneficiary of a health-benefit plan governed by the Employee Retirement and Income Security Act of 1974 (ERISA) defeat enforcement of the plan's valid equitable lien by agreement by spending the fund subject to the lien? The existence of the deep circuit split over this question is undisputed; indeed, the Solicitor General recognized the split in his invitation brief in *Thurber* v. *Aetna Life Insurance Co.*, No. 13-130. The importance of the question presented is likewise undisputed; its resolution will affect the affordability of plans that are responsible for paying benefits to over 132 *million* people. *See* William Pierron & Paul Fronstin, Employee Benefit Research

Inst., *ERISA Pre-emption: Implications for Health Reform and Coverage* 1 (Feb. 2008). Respondent therefore agrees that now is the time for this Court to grant review and resolve the question.

The parties part ways, however, when it comes to how the question should be resolved. The Eleventh Circuit got this case exactly right: a plan beneficiary who accepts medical-expense payments from an ERISA plan that requires the beneficiary to reimburse the plan out of any third-party recovery cannot avoid his side of the bargain by spending down and dissipating that recovery. A contrary finding would upend the basic assumptions underlying ERISA plans and the careful balance struck by the reimbursement provisions in those plans.

The arrangement struck by plans and beneficiaries is mutually beneficial. On one side of the balance, a covered employee injured by the fault of another is guaranteed that his medical bills will be paid, free from the uncertainty and delay that often accompanies suing an underinsured or judgment-proof tortfeasor. But, on the other side, health plans reasonably do not want to spend their limited resources paying medical bills that could, and should, have been paid by the actual wrongdoer. So ERISA plans often include a reimbursement clause offering a tradeoff: the plan will pay the beneficiary's medical bills upfront, without regard to fault, so long as the beneficiary agrees to use any tort recovery he later obtains to reimburse the plan. The clause ensures a more-equitable allocation of plan resources and lower rates for all beneficiaries.

Beneficiaries have long resisted reimbursement provisions, decrying them as unfair in their particu-

lar circumstances. But time and again, this Court has held that if a reimbursement provision is properly drafted, it may be enforced under ERISA's Section 502(a)(3), which allows a plan fiduciary to seek "appropriate equitable relief" to enforce the plan's terms. 29 U.S.C. § 1132(a)(3)(B).

In *Sereboff* v. *Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), the Court held that a plan's suit to enforce a reimbursement clause seeks equitable relief because the action is akin to one to enforce an "equitable lien by agreement"—a traditional equitable remedy. And in *US Airways, Inc.* v. *McCutchen*, 133 S. Ct. 1537 (2013), the Court rejected a beneficiary's claim that a plan's recovery under a reimbursement provision should be subject to various equitable offsets. A court enforcing a valid reimbursement provision, the Court held, applies the terms of the clause as written.

Some beneficiaries nonetheless continue to resist repayment. This case involves the latest such technique: Claiming that the plan cannot enforce its lien because the beneficiary has already spent the money he agreed to repay. This strategy has had some success. The Ninth Circuit ruled in favor of a beneficiary who had done just that. And the Eighth Circuit ruled in favor of a beneficiary's attorney after concluding that a claim for repayment of monies no longer held sought legal, not equitable, relief. The Eleventh Circuit below, however, joined the majority view of five of its sister circuits and recognized that later dissipation is irrelevant under *Sereboff* so long as the beneficiary possessed the sought-after funds at some point.

Both plans and beneficiaries have sought this Court's review of this acknowledged split in the past, but vehicle problems appear to have prevented the Court from doing so. This case is an appropriate vehicle to address the question once and for all. The judgment below is final, and Petitioner concedes that his plan's reimbursement clause is valid and enforceable but for his claim of dissipation. And though the Eleventh Circuit's holding is manifestly correct, the contrary rule lingering in other circuits creates uncertainty that harms plans and beneficiaries alike.

The Court should grant certiorari.

COUNTERSTATEMENT

1. ERISA comprehensively regulates most private-sector employee benefit plans that provide benefits in the event of sickness, accident, disability, or death. *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 44 (1987). The statute is designed to facilitate the "fair and prompt enforcement of rights" created under those plans. *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 215 (2004). ERISA does not require employers to offer a benefit plan in the first place, nor does it "mandate what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 887 (1996). But once an employer chooses to offer a benefit plan, the statute's regulatory regime kicks in: ERISA requires disclosure of certain information; sets standards for plan administration and asset management; and includes "carefully integrated civil enforcement provisions" available to plan participants, plan fiduciaries, and the Secretary of Labor. *Massachusetts Mut. Life Ins.*

Co. v. *Russell*, 473 U.S. 134, 146 (1985); *see* 29 U.S.C. §§ 1001(b), 1132(a).

Section 502 of ERISA contains the statute's civil enforcement provisions. *See* 29 U.S.C. § 1132. Subsection (a)(1) authorizes plan participants to file civil actions seeking the usual panoply of legal remedies. Plan fiduciaries have more limited options, however. They must resort to subsection (a)(3), which provides that a fiduciary may seek an injunction or "other appropriate equitable relief" to enforce the terms of a written benefit plan or the statute itself. 29 U.S.C. § 1132(a)(3)(B). This Court has construed Section 502(a)(3) to authorize only "those categories of relief that were typically available in equity" during the days of the divided bench. *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 255-256 (1993) (emphasis omitted).

2. Petitioner Robert Montanile was a beneficiary of a welfare benefit plan administered by the Respondent, the Board of Trustees of the National Elevator Industry Health Benefit Plan. Pet. App. 2a-3a. When Montanile was injured in a car accident, the Plan paid his initial medical expenses, totaling $121,044.02. *Id.* at 6a.

The Plan is governed by ERISA, *id.* at 3a, and, like many plans, includes provisions addressing the Plan's rights if it pays for medical expenses caused by a third party, *id.* at 5a. The Plan states that a beneficiary's "[a]cceptance of benefits from the Plan for an injury or illness * * * constitutes an agreement that any amounts recovered from another party * * * will promptly be applied first to reimburse the Plan in full for benefits advanced by the Plan due to the injury or illness." *Id.* at 5a-6a. The Plan further

provides that the Plan is entitled to reimbursement for all amounts paid, "without reduction for attorneys' fees, costs, [or] expenses." *Id.* at 6a.

In other words, by accepting benefits from the Plan following his accident, Montanile agreed to reimburse the Plan on a first-dollar basis from any judgment or settlement he obtained. *See* Pet. 11 (agreeing that the Plan's reimbursement provision is valid). Indeed, Montanile signed an agreement expressly acknowledging the Plan's reimbursement rights before the Plan paid his medical expenses. *See* D. Ct. Dkt. No. 36-5 at 1.

Montanile sued the drunk driver at fault in his accident and eventually obtained a $500,000 settlement. Pet. App. 6a. The Plan asked Montanile to honor his reimbursement agreement, but Montanile refused. *Id.* at 7a. Montanile instead asked the Plan to compromise its lien, even though over $235,000 remained after Montanile paid his attorneys and their out-of-pocket expenses. *See id.* at 6a-7a.

After a series of proposals and counter-proposals, the Plan and Montanile reached an impasse. *See* D. Ct. Dkt. No. 35-2 at 3. Rather than satisfy the Plan's lien or seek a declaratory judgment as to the Plan's right to the funds, however, Montanile's counsel released the money to him, less their fee. *Id.* Montanile says that he then spent the money. Pet. App. 36a.

2. The Plan sued Montanile in federal court, invoking Section 502(a)(3)'s civil remedy to enforce the Plan's reimbursement provision. Pet. App. 7a. Applying this Court's decisions in *Sereboff* and *McCutchen*, the District Court held that Montanile's agreement to repay the Plan any amount recovered

from another party gave the Plan an equitable lien by agreement over the settlement funds—a form of "appropriate equitable relief" under Section 502(a)(3). Pet. App. 25a-30a. Montanile nonetheless maintained that the Plan could not enforce its lien because he had spent the settlement funds. *Id.* at 35a.

The District Court disagreed and granted the Plan summary judgment. *Id.* at 35a-42a. "Following the majority view," the District Court "conclude[d] that any dissipation of the settlement funds by [Montanile] is immaterial" to the Plan's right of recovery. *Id.* at 41a. So long as Montanile had possessed the funds at some point—and he had—Montanile could not evade enforcement of the Plan's lien by spending the money he had promised to turn over. *Id.* at 42a.

3. The Eleventh Circuit affirmed, relying on its recent holding in *AirTran Airways, Inc.* v. *Elem*, 767 F.3d 1192 (11th Cir. 2014). Pet. App. 10a-11a.

In *Elem*, the Eleventh Circuit rejected a dissipation argument identical to Montanile's. The court of appeals held that "[i]t matters not whether the settlement funds have since been disbursed or commingled with other funds." *Id.* at 53a. Rather, "[a]s soon as the settlement fund was identified, the plan imposed an equitable lien over that fund even thought it was in the hands of the beneficiaries." *Id.* at 54a. And the " '[p]roperty to which the lien attached may be converted into other property without affecting the efficacy of the lien.' " *Id.* (quoting *Funk* v. *CIGNA Grp. Ins.*, 648 F.3d 182, 194 (3d Cir. 2011) and citing *Central States, Se. & Sw. Areas Health & Welfare Fund* v. *Lewis*, 745 F.3d 283, 285 (7th Cir. 2014), *Thurber* v. *Aetna Life Ins. Co.*, 712 F.3d 654,

663-664 (2d Cir. 2013), *Cusson* v. *Liberty Life Assur. Co. of Boston*, 592 F.3d 215, 231 (1st Cir. 2010), *Longaberger Co.* v. *Kolt*, 586 F.3d 459, 466-467 (6th Cir. 2009), and *Popowski* v. *Parrott*, 461 F.3d 1367, 1374 n.8 (11th Cir. 2006)). As a result, even where a plan beneficiary "willfully refuse[s] to abide by the terms of" a plan, the beneficiary's "dereliction * * * could not destroy the lien that attached" before dissipation. *Id.* And that holding was fatal to Montanile's claims in his appeal. *Id.* at 10a-11a (noting Montanile's agreement that *Elem* foreclosed his dissipation argument).

This petition followed.

ARGUMENT

I. THERE IS AN ENTRENCHED SPLIT ON THE QUESTION PRESENTED, AND THIS CASE IS AN APPROPRIATE VEHICLE TO RESOLVE IT.

Although the parties disagree on the merits, they are aligned on two critical points. The Court should grant the petition to settle this important statutory question, and the petition is an appropriate vehicle for that review.

A. The Courts of Appeals Are Split On The Question Presented.

Respondent agrees with Montanile: there is a deep, acknowledged split among the courts of appeals on the question of whether a beneficiary can evade enforcement of an ERISA plan's otherwise-valid reimbursement clause by spending the funds the beneficiary promised to return to the plan. Pet. 15-17. The split is lopsidedly against Montanile, but it shows no sign of resolving. This Court should there-

fore grant the writ to bring uniformity to the courts of appeals. Sup. Ct. R. 10(a).

1. In *Sereboff*, the Court held that an ERISA fiduciary may enforce a reimbursement provision like the one in the Plan here because "it is indistinguishable from an action to enforce an equitable lien established by agreement." 547 U.S. at 368. An equitable lien by agreement, the Court explained, is different from a legal damages claim because the fiduciary seeks "to recover a particular fund from the defendant." *Id.* at 363. Thus, the fiduciary "could bring an action under § 502(a)(3) seeking the funds that its beneficiaries had promised to turn over." *McCutchen*, 133 S. Ct. at 1545.

In the wake of *Sereboff*, beneficiaries began to argue that their plans' reimbursement claims were unenforceable because the beneficiaries had spent the money they had promised to turn over. Because there was supposedly no longer "a particular fund" in their possession, the beneficiaries asserted, all that remained was a legal claim for damages that was not cognizable under Section 502(a)(3). *See, e.g.*, *Funk*, 648 F.3d at 194.

For years, the courts of appeals uniformly rejected these arguments. The Seventh Circuit explained that enforcement of a plan's lien under *Sereboff* "is not dependent on the ability to trace particular funds." *Gutta* v. *Standard Select Trust Ins. Plans*, 530 F.3d 614, 621 (7th Cir. 2008). Thus, the beneficiary's plan could bring its claim under Section 502(a)(3) "even if the benefits it paid [to the beneficiary] are not specifically traceable to [the beneficiary's] current assets because of commingling or dissipation." *Id.*

Other courts concurred. A year after the Seventh Circuit, the Sixth held that "an equitable lien by agreement does not require tracing or maintenance of a fund in order for equity to allow repayment." *Longaberger*, 586 F.3d at 466. The First Circuit similarly found that a plan's equitable lien by agreement was enforceable even though the plan "ha[d] not identified a specific account in which the funds are kept or proven that they are still in [the beneficiary's] possession." *Cusson*, 592 F.3d at 231. And the Third Circuit concluded that if "there was an equitable lien by agreement * * *, dissipation of the funds was immaterial." *Funk*, 648 F.3d at 194. The beneficiary, the Third Circuit held, "need not possess the property at the time relief is sought in order for the relief to be equitable—any post-agreement possession will suffice." *Id.* at 194 n.14.

2. As the petition recognizes, the Ninth Circuit split from its sister circuits in *Bilyeu* v. *Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083 (9th Cir. 2012). *See* Pet. 16. The court acknowledged that "a number of circuits" had held that "a fiduciary can assert an equitable lien * * * even if the beneficiary no longer possesses the specifically identified funds." *Bilyeu*, 683 F.3d at 1094 (citing, among others, *Funk*, *Cusson*, *Longaberger*, and *Gutta*). But it nonetheless concluded that the other circuits had erred in holding that *Sereboff* allowed a fiduciary to enforce "an equitable lien against a beneficiary's general assets when specifically identified funds are no longer in a beneficiary's possession." *Id.* at 1095 (emphasis omitted).

In the Ninth Circuit's view, "the fiduciary must recover from specifically identified funds *in the beneficiary's possession*." *Id.* Thus, if a beneficiary

spends his settlement funds before a plan can file suit, the plan is simply out of luck. *Id.* at 1096-97. The plan in *Bilyeu* sought rehearing en banc and certiorari, but both were denied. *See* Pet. App. 59a, *First Unum Life Ins. Co.* v. *Bilyeu*, No. 12-526 (denying rehearing); 133 S. Ct. 1242 (2013) (denying certiorari).

The petition also notes that, after *Bilyeu*, the Eighth Circuit followed the Ninth Circuit's minority view. *See* Pet. 9, 15-16; *Treasurer, Trustees of Drury Indus., Inc. Health Care Plan & Trust* v. *Goding*, 692 F.3d 888 (8th Cir. 2012). In that case, the plan pursued relief against a beneficiary's counsel who had held settlement funds for the beneficiary. The Eighth Circuit concluded that where that counsel "no longer has any money to which [the plan] claims an interest," the plan's resulting claim is "legal, not equitable," and therefore not cognizable under Section 502(a)(3). *Goding*, 692 F.3d at 897. The plan in *Goding* also sought rehearing en banc and certiorari, but both were denied. Pet. App. 23a, *Treasurer Trustees of Drury Indus., Inc. Health Care Plan & Trust* v. *Goding*, No. 12-982 (denying rehearing); 133 S. Ct. 1644 (2013) (denying certiorari).

The next circuit to address the dissipation question, the Second, recited the established majority and minority views. *Thurber*, 712 F.3d at 663. The court then cast its lot with the majority, concluding that the rule "strikes the right balance" between plan and beneficiary. The court also explicitly "reject[ed] the Ninth Circuit's contrary view that [plans] may not reach specifically identified assets that have dissipated." *Id.* at 664. It explained that "[i]n the context of an equitable lien by agreement * * * all that matters is that the beneficiary did, at some point,

have possession and control of the specific portion of the particular fund sought by the insurer." *Id.*

This time, when the beneficiary sought certiorari, the Court called for the views of the Solicitor General. And the Solicitor General's brief in response confirmed that "the courts of appeals are divided on th[e] question" of whether an equitable lien by agreement may be enforced under Section 502(a)(3) when the beneficiary claims that he has spent the funds. Br. of the United States as Amicus Curiae, *Thurber* v. *Aetna Life Ins. Co.*, No. 13-130, at 6 (May 2014) (U.S. *Thurber* Br.). On the merits, the Solicitor General explained that, in the view of the United States, the Ninth Circuit's minority position was correct. *Id.* at 9-15. But the Solicitor General concluded that *Thurber* was a poor vehicle to address the question presented because it was not clear that the language of the plan even created a claim for equitable relief in the first place, *id.* at 15-20, and this Court denied the writ, 134 S. Ct. 2723 (2014).

3. The decision below, which follows directly from the Eleventh Circuit's application of *Elem*, raises the same issue that seven other circuits have analyzed and resolved. Pet. App. 53a-55a. The disagreement is sufficiently entrenched that only this Court can resolve it, and it is sufficiently important that the Court should do so now. Each circuit starting with *Bilyeu* acknowledged or was made aware of the split, but declined to rehear the issue *en banc* when asked to do so. The Court should step in to bring national uniformity on this important question of ERISA practice.

B. This Case Is An Appropriate Vehicle To Resolve This Important Question Of ERISA Practice.

The parties also agree that Montanile's petition is an appropriate vehicle to resolve this important question. Pet. 1, 18-22. Unlike previous cases, the validity of the Plan's equitable lien by agreement is uncontested in this Court. The question is therefore cleanly presented. And because both plans and beneficiaries desperately need clarification as to whether a beneficiary can evade enforcement of a plan's reimbursement provision by reneging on his promise, the petition should be granted.

1. Each of the prior petitions for certiorari since the split developed appear to have presented vehicle problems. *Bilyeu*, for instance, was in an interlocutory posture, 683 F.3d at 1096 (directing further proceedings on remand), which traditionally weighs against immediate certiorari review. *See Hamilton-Brown Shoe Co.* v. *Wolf Bros. & Co.*, 240 U.S. 251, 258 (1916); *see also Virginia Military Inst.* v. *United States*, 508 U.S. 946 (1993) (Scalia, J., concurring).

Thurber, meanwhile, would have required resolving "a logically antecedent issue * * * regarding whether the particular plan language at issue is sufficient to create a claim for equitable relief at all." U.S. *Thurber* Br. 5. The Solicitor General opined that the plan terms at issue were not sufficient, and that there was no compelling reason for the Court to review the Second Circuit's factbound contrary finding. *Id.* at 15-20. And in her supplemental brief, the plan beneficiary embraced the threshold issue the United States had identified, confirming that the question presented was not necessarily presented after all.

See Petitioner's Supplemental Brief, *Thurber* v. *Aetna Life Ins. Co.*, 2014 WL 2120372, at *6-*11 (May 16, 2014).

Montanile's petition presents neither obstacle. The District Court's order is final; Montanile has been ordered to reimburse the Plan. Pet. App. 44a. And though Montanile argued in the court of appeals that the Plan documents did not create an equitable lien by agreement, *id.* at 11a-17a, his petition affirmatively abandons that claim, Pet. 11 n.4. There is therefore no threshold issue of plan interpretation, as there was in *Thurber*, that would inhibit this Court's review of the dissipation issue.

In short, the petition cleanly presents the question that has divided the circuits, and it does so on a typical set of facts. The petition is therefore an appropriate vehicle for this Court to resolve the split.

2. The question presented also has a tremendous practical impact on ERISA plans and beneficiaries. For large, multi-state plans like the one here, the disagreement among the courts of appeals means that the enforceability of a single plan's reimbursement clause may vary between California and Florida. That is contrary to ERISA's core purpose, which is to "induc[e] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 379 (2002). And the "patchwork scheme" of regulation created by the circuit split will "introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those

without such plans to refrain from adopting them." *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 11 (1987); *see also Varity Corp.* v. *Howe*, 516 U.S. 489, 497 (1996) (ERISA was meant to "create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place"). That is harmful to plans and beneficiaries alike.

Permitting the split to linger may also lead to increased rates. Estimates suggest that plans recover more than $1 billion annually under reimbursement provisions. *See* Br. of Amicus Curiae America's Health Ins. Plans, Inc. *et al.* in Support of Respondent, *Sereboff*, No. 05-260, 2006 WL 460877, at *3 n.3. The minority position on dissipation will cost plans a portion of those reimbursements, because beneficiaries in those circuits have every incentive to spend every dollar of settlement funds immediately upon receipt. And that reduction in plan recoveries will have to be passed along to others. As the Eleventh Circuit has explained, where a beneficiary is "relieved of his obligation to reimburse [a plan] for the medical benefits it paid on his behalf, the cost of those benefits [will] be defrayed by other plan members and beneficiaries in the form of higher premium payments." *Zurich Am. Ins. Co.* v. *O'Hara*, 604 F.3d 1232, 1238 (11th Cir. 2010); *see also Cutting* v. *Jerome Foods, Inc.*, 993 F.2d 1293, 1297 (7th Cir. 1993) (Posner, J.) (without reimbursement, a plan member "pays more for the insurance"). A decline in reimbursement affects more than the individual beneficiaries involved in a particular case; it impacts *all* plan beneficiaries.

A significant reduction in reimbursement recoveries could, in fact, cost employees their health insur-

ance: "[E]ach one percent increase in * * * plans' costs * * * results in a potential loss of insurance coverage for about 315,000 individuals." Health Economics Practice, Barents Group, LLC, *Impacts of Four Legislative Provisions on Managed Care Consumers: 1999-2003*, at iii (1998). The Court should not leave in place a split that risks that negative consequence.

Ultimately, plans require certainty going forward. If there is a single, national rule—whatever it is—then plans can price reimbursement or a lack of reimbursement into their rates. What they cannot easily plan for is the current disarray. That is why several industry organizations—the American Council of Life Insurers, America's Health Insurance Plans, The American Benefits Council, and Sun Life Insurance Company of Canada—filed briefs as *amici curiae* in *Bilyeu* asking this Court to resolve the issue. The petition should be granted.

II. THE ELEVENTH CIRCUIT'S DECISION IS CORRECT.

The parties' agreement comes to an end at the merits. This Court should recognize what precedent and historic equity practice confirm: an equitable lien by agreement may be enforced even where the promisor has dissipated the funds subject to the lien. Montanile's contrary view guts the relief this Court held was available in *Sereboff* and *McCutchen*.

1. *Sereboff* refutes Montanile's argument that a beneficiary must possess the identified funds at the time of suit for a plan to enforce its equitable lien by agreement. Under *Sereboff*, the lien attaches " 'as soon as [the beneficiary] gets a title to the thing' "—here, Montanile's settlement from his tortfeasor. 547

U.S. at 364 (citation omitted). At that point, a perfected equitable lien by agreement exists. And *Sereboff* says that the lien remains valid even if the moneys later cannot be traced to " 'some particular funds or assets.' " *Id.* (citation omitted).

That holding forecloses a continual-possession requirement. If the money cannot be traced to a "particular fund or assets," then there is no way the fiduciary could know whether the participant is still in possession of the funds. And yet *Sereboff* holds that the fiduciary can still recover in those circumstances. *Id.* at 365 ("no tracing requirement of the sort asserted by the Sereboffs applies to equitable liens by agreement or assignment"). After *Sereboff*, the focus is not on tracing formalities, but on a pragmatic, three-prong test. Where (1) a beneficiary agreed to repay moneys out of a fund; (2) the fund, and the moneys to be repaid, are specifically identified, and (3) the participant had title to the identified funds, the beneficiary's promise will be enforced in equity. *See id.* at 363-367. Nothing else is required.

Claiming the contrary, Montanile relies (Pet. 17) on this Court's statement that "where 'the property [sought to be recovered] or its proceeds have been dissipated so that no product remains, [the plaintiff's] claim is only that of a general creditor' " and the plaintiff " 'cannot enforce a constructive trust or an equitable lien upon other property of the [defendant].' " *Great-West Life & Annuity Ins. Co.* v. *Knudson*, 534 U.S. 204, 213 214 (2002) (quoting *Restatement of Restitution & Unjust Enrichment* § 215 cmt.a (1936)) (alterations in *Knudson*). As Montanile sees it, *Knudson* establishes a present-possession requirement for all equitable liens, including the Plan's equitable lien by agreement.

But *Sereboff* considered—and disagreed with—that very argument. The Court rejected the Sereboffs' argument that "*Knudson* endorsed application of all the restitutionary conditions—including restitutionary tracing rules—to every action for an equitable lien under § 502(a)(3)." 547 U.S. at 365. The Court also explained that *Knudson* did not "catalog all the circumstances in which equitable liens were available in equity"; "the Court concluded only that equitable restitution was unavailable because the funds sought were not [in the beneficiary's] possession" but had been placed in a trust. *Id.* Indeed, the settlement funds in *Knudson* were *never* in the beneficiary's possession, so the lien never attached to anything held by the beneficiary. *See Knudson*, 534 U.S. at 208 (explaining that the "state court's order provided that the defendants would pay the settlement amount allocated to the Special Needs Trust directly to the trust").

Knudson, in other words, was far more modest than Montanile thinks. All it did was "describe[ ] in general terms the conditions under which a fiduciary might recover when it was seeking equitable restitution." *Sereboff*, 547 U.S. at 365. Equitable restitution and equitable liens by agreement are "different species of relief" with different requirements and incidents. *Id. Knudson* dealt only with equitable restitution, on facts where the beneficiary never had possession of the fund at issue, and *Sereboff* directly addressed equitable liens by agreement. *Sereboff* thus confirms that tracing is not required to enforce an equitable lien by agreement. 547 U.S. at 364.

2. *Sereboff*'s guidance regarding tracing and equitable liens by agreement is in line with historic equity practice. Equitable liens were generally

enforced through foreclosure of the identified property or fund. D. Dobbs, *Law of Remedies* § 1.4 (2d ed. 1993). But a debtor could not defeat the lien by alienating the property or dissipating the fund. As Justice Holmes made clear in a related context, a plaintiff who sought "the recovery of an identified fund" was entitled to equitable relief even if it later turned out that "the fund [was] gone." *Otis* v. *Otis*, 45 N.E. 737, 737 (Mass. 1897). In such circumstances, the court would award "compensation as alternative relief." *Id.*

The Federal Equity Rules this Court promulgated during the days of the divided bench codified this principle. Rule 10 provided that "[i]n suits for the foreclosure of mortgages, or for the enforcement of other liens, a decree may be rendered for any balance found to be due to the plaintiff over and above the proceeds of the sales or sales" of the property that was subject to the lien and "execution may issue for the collection of the same." Fed. Equity R. 10 (1912). Courts recognized that the rule "authorized" equity courts to issue deficiency decrees, *Phelps* v. *Loyhed*, 19 F. Cas. 461, 461 (C.C.D. Minn. 1871) (No. 11,077), and gave plaintiffs an equitable "remedy for the enforcement of existing rights," *Continental-Equitable Title & Trust Co.* v. *National Props. Co.*, 273 F. 967, 970 (D. Del. 1921). Montanile's claim that equity left lienholders without a remedy is contrary to this established practice.

Monetary relief when the property securing a lien had been dissipated was perfectly consistent with broader equitable principles. Equity courts had long awarded compensation "where no such remedy lies at law, * * * in order to prevent irreparable mischief, or to avoid a fraudulent advantage being taken of the

injured party." 2 J. Story, *Commentaries on Equity Jurisprudence* § 798, at 135 (5th ed. 1849). And equitable liens by agreement are particularly well-suited to that mode of enforcement. They are, after all, "merely a means to the end of satisfying a claim for the recovery of money"; the " '*real* remedy, the final object of the proceeding, is the pecuniary recovery.' " *Department of the Army* v. *Blue Fox, Inc.*, 525 U.S. 255, 262-263 (1999) (quoting 1 J. Pomeroy, *Equity Jurisprudence* § 112 (5th ed. 1941)).

All of this points up at a bigger principle: Equity jurisdiction is founded on the maxim that " '[e]quity suffers not a right to be without a remedy.' " *CIGNA Corp.* v. *Amara*, 131 S. Ct. 1866, 1879 (2011) (quoting R. Francis, *Maxims of Equity* 29 (1st Am. ed. 1823)). But that is just what Montanile's position would do; it would leave plans with no way to enforce their otherwise-valid reimbursement provisions when Section 502(a)(3) reflects congressional intent to allow for just such a remedy. That would create perverse incentives for beneficiaries: A beneficiary who honors his legal obligation to reimburse his plan would be *worse off* than a beneficiary who reneges and spends the funds he promised to turn over. Montanile never explains how equity could countenance that truly inequitable result or how it would be in keeping with ERISA's enforcement scheme. This Court, like the Eleventh Circuit below, should reject Montanile's argument on the merits.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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No. 14-723

IN THE

Supreme Court of the United States

ROBERT MONTANILE,

Petitioner,

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Respondent.

On Writ of Certiorari to the
United States Court of Appeals
for the Eleventh Circuit

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INTRODUCTION

This was a good-faith contract dispute involving complex questions, including one that split the circuits and took this Court to resolve. Mr. Montanile lost. Now, the question before this Court is whether ERISA permits Respondent to obtain damages for Mr. Montanile's breach through an "equitable lien by agreement" against his general assets. The answer is no.

Liens offer recourse against specific property, not persons. That is true whether the lien is statutory or equitable. And it is true whether the lien is imposed to avoid unjust enrichment or by agreement.

Under the label of "equitable lien by agreement," the decision below approved a personal money judgment against the general assets of Mr. Montanile. That was error. An agreement can define the scope of property to which a lienholder is entitled. But no agreement can create a lien that is enforceable against something other than specific property. That is simply not a lien. It is an attempt "'to impose personal liability for a contractual obligation to pay money.'" *Sereboff* v. *Mid Atl. Med. Servs.*, 547 U.S. 356, 363 (2006) (quoting *Great-West Life & Annuity Ins. Co.* v. *Knudson*, 534 U.S. 204, 210 (2002)).

Respondent labors to read this Court's cases differently. Br. 13-25. But as explained by Petitioner and the United States, it cannot. Pet. Br. 16-36; U.S. Br. 8-18. Undeterred, Respondent invites this Court to declare prior "equitable relief" cases a dead letter. *See* Br. 23 (this Court has "effectively limited *Mertens* and *Great-West* to their facts."). But those cases have reflected this Court's law for over two decades, and the Court has repeatedly invoked those cases in its recent decisions.

Respondent cannot wish them away because it dislikes the result.

As a doctrinal hook, Respondent offers two new remedies never before considered by this Court (or the courts below) in an ERISA case: (i) the substitutionary monetary decree and (ii) the deficiency judgment. Br. 36-46. But as Petitioner and the United States have explained, both are legal remedies occasionally awarded by pre-merger equity courts. Pet. Br. 36-42; U.S. Br. 21-26. Respondent offers little, if any, response.

Instead, Respondent pins its hopes for affirmance on this Court's policy heartstrings. Letting ERISA participants and beneficiaries avoid repayment, it argues, will unacceptably drive up the cost of plans. Br. 46-57. Come hell or high-court intervention, Respondent declares, Mr. Montanile must pay.

Aside from being directed at the wrong institution, Respondent's policy arguments are overblown. Similarly situated litigants said precisely the same thing nearly fifteen years ago in *Great-West*. Since then, the world has not crumbled, and Congress has not rushed in to correct this Court's alleged error. As this Court and ERISA litigants well know, Congress' decision to limit 29 U.S.C. § 1132(a)(3) to "equitable relief" has its pluses and minuses. But it is up to Congress, and Congress only, to change that equation.

I. An Equitable Lien by Agreement Cannot Be Enforced Against General Assets.

A. In *Great-West*, this Court made clear that an equitable lien under ERISA may only be enforced against specific property in the possession of a beneficiary—never against general assets. 534 U.S. at 213-14.

In *Sereboff*, this Court reaffirmed that core principle. 547 U.S. at 361-63 (Section II.A) (holding that the nature of the recovery sought by Mid Atlantic was equitable because the present possession requirement was met). Indeed, in Section II.A of its opinion, *Sereboff* expressly held that:

- The "impediment to characterizing the relief in [*Great-West*] as equitable is not present here [because] Mid Atlantic sought funds that were set aside and 'preserved [in the Sereboffs'] investment accounts.'" *Id.* at 363;
- "Unlike Great-West, Mid Atlantic did not simply seek 'to impose personal liability for a contractual obligation to pay money.'" *Id.* (quoting *Great-West*, 534 U.S. at 210); and
- Mid Atlantic "sought its recovery through [an] equitable lien on a specifically identified fund, not from the Sereboffs' assets generally, as would be the case with a contract action at law." *Sereboff*, 547 U.S. at 363.

Only after making clear that present possession is a threshold requirement for the enforcement of any equitable lien did this Court address the *additional* requirements for enforcement of an equitable lien by agreement. *See Sereboff*, 547 U.S. at 363-69 (Section II.B) (holding that the basis for the claim asserted by Mid Atlantic was also equitable).

B. Nonetheless, Respondent insists that the issue remains open for two reasons:

1. Respondent argues that *Sereboff* actually supports its "lien-on-general assets" position. Br. 13-19. According to Respondent, *Great-West* was limited to

"only the type of 'equitable lien' that is 'intended to prevent unjust enrichment.'" Br. 18 (internal cites omitted). And, Respondent says, *Sereboff* actually endorsed the proposition that equitable liens by agreement are quasi-contracts entitling the lienholder to recover damages if the debtor no longer possess the pledged res. Br. 17. Not so.

In *Sereboff*, the plan participant and beneficiary (represented by the same counsel now representing Mr. Montanile) argued that the equitable lien sought by the ERISA plan fiduciary (Mid Atlantic) could not be enforced because the third-party tort settlement, although currently in the Sereboffs' possession, was not traceable to specific property that Mid Atlantic had originally possessed.[1]

The Court rejected that type of tracing requirement, explaining that unlike equitable liens sought to avoid unjust enrichment, equitable liens *by agreement* can reach things even if they were never in plaintiff's possession. But nothing in *Sereboff* holds or suggests that an equitable lien by agreement can somehow make a lien enforceable against the debtor's general assets. And that is the proposition—"a lien-on-general-assets" theory—that Respondent must defend.

Sereboff made quite clear that present possession of the res is a condition for *all* equitable liens—*i.e.*, whether to avoid unjust enrichment or by agreement. Indeed, as the United States has explained, that entire section of the *Sereboff* opinion would have been

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[1] The Fourth Circuit in *Sereboff* had imposed an equitable lien of the *Great-West* variety—*i.e.*, to avoid unjust enrichment. Consequently, the Sereboffs' principal argument in its opening brief in this Court was one of tracing. *See* Brief for Petitioners at 17-23, *Sereboff v. Mid Atl. Med. Servs.*, 547 U.S. 356 (2006) (No. 05-260).

unnecessary if, as Respondent suggests, a lien by agreement can operate without a debtor in possession of the res. U.S. Br. 13-17. Respondent offers no response.

2. In an implicit concession that its position would be foreclosed by *Mertens* and *Great-West*, Respondent asserts that *CIGNA Corp.* v. *Amara*, 131 S. Ct. 1866 (2011) "effectively limited *Mertens* and *Great-West* to their facts." Br. 23. *CIGNA* did no such thing, and Respondent's contrary characterization is meritless.

According to Respondent, *CIGNA* proves that "'money payment[s],'" even "*compensatory*" payments, fell within "'the category of traditionally equitable relief.'" Br. 24 (emphasis in original) (quoting *CIGNA*, 131 S. Ct. at 1879). But this simply ignores that *CIGNA*'s logic was rooted directly in the particular claim at issue: unlike the vast majority of equity cases, in fiduciary cases, monetary damages may be recovered from a breaching *fiduciary's* general assets because of the specific equitable remedy of surcharge. *See CIGNA*, 131 S. Ct. at 1880 (citing multiple sources explicitly discussing actions against "trustees" for "a breach of trust").

That rule is exactly the opposite of the traditional rules that apply in all *non-fiduciary* settings. And that is why *CIGNA* itself—in a passage Respondent conspicuously ignores—specifically distinguished *CIGNA*'s fact pattern from the Court's other cases: "Thus, insofar as an award of make-whole relief is concerned, the fact that the defendant in this case, *unlike the defendant in Mertens*, is analogous to a trustee *makes a critical difference*." *Ibid.* (emphases added).

"[A]ppropriate equitable relief" is not a one-size-fits-all proposition; relief *appropriate* for one defendant may

not be appropriate for others. Respondent has no logical basis for presuming that *CIGNA*'s remedies against fiduciaries would apply in all cases, including those against beneficiaries; and Respondent has especially no reason to draw that conclusion in light of *CIGNA*'s express statement distinguishing those cases on this "critical difference."

But Respondent need not take this Court's word for it. Congress itself drew the very same line in ERISA's remedial scheme, crafting different remedies in suits for and against fiduciaries. *Compare* 29 U.S.C. § 1109(a) (authorizing litigation to recover from personal assets any losses caused or gains to a breaching "fiduciary"); 29 U.S.C. § 1132(a)(2) (authorizing "participant[s]" and "beneficiar[ies]," among others, to bring actions under Section 1109), *with* 29 U.S.C. § 1132(a)(3) (limiting recovery to "appropriate equitable relief").

Accordingly, Respondent is mistaken that *CIGNA* (without saying so) intended to sharply limit *Mertens* and *Great-West*—particularly when it expressly relied on those cases and distinguished them on a firmly grounded "critical difference." As *CIGNA* separately explained, "traditionally speaking, relief that sought a lien or a constructive trust was legal relief, not equitable relief, unless the funds in question were '*particular* funds or property in the defendant's possession.'" 131 S. Ct. at 1879 (quoting *Great-West*, 534 U.S. at 213) (emphasis in original). *See also Sereboff*, 547 U.S. at 363 (reaffirming exactly that rule from *Great-West*).[2]

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[2] In attempting to distinguish this Court's cases, Respondent suggests that "dissipation" is relevant only for "restitution or unjust enrichment," not "equitable lien[s] by agreement." Br. 32-33. This contention is inconsistent with *Sereboff*, which plainly treated the line in *Great-West* as controlling. The Court never once said that

C. This Court's precedent forecloses Respondent's argument. But even revisiting first principles, Respondent's version of pre-merger equity practice is demonstrably wrong.

1. Respondent, as its lead argument, argues that the foundational principle of equity is that there are "no rights without remedies." Br. 26-27. Respondent's decision to focus at the highest possible level of generality is telling: If there were any merit to Respondent's doctrinal position, it would lead with precedent, not platitudes. But Respondent cannot support its position with any cases or treatises that directly raise and resolve this question in its favor. Congress was well aware that limiting relief to "appropriate *equitable* remedies" would mean that certain harms remediable only at law would go unaddressed. Respondent cannot invoke a general aim of providing relief to overcome the specific limits on equitable doctrine. *Cf., e.g., Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring) ("A series of the Court's decisions has yielded a host of situations in which persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief.").

(i) the remedy was allowed because the defendant *once* had possession; or (ii) *Great-West* is distinguishable because it supposedly involved restitution or a different kind of equitable lien. *Sereboff*, 547 U.S. at 362-63. *Sereboff*'s sole rationale was that the remedy was equitable because the "impediment to characterizing the relief in [*Great-West*] as equitable is not present here"—"Mid Atlantic sought 'specifically identifiable' funds that were 'within the possession and control of the Sereboffs.'" *Ibid.* This is why the relief did not impermissibly target "the Sereboffs' assets generally." *Id.* at 363. This Court presumably meant what it said, and Respondent has offered no sound basis for thinking otherwise.

Respondent says its rule would not "render Section 502(a)(3)'s distinction between legal and equitable remedies superfluous," Br. 27, but that is exactly what it would do. If it were sufficient to identify an "equitable lien by agreement," for example, then cases like *Sereboff*—would start and stop with a simple finding that the beneficiary breached an agreement and was automatically compelled "'to perform his duty rather than violate it.'" *Id.* (citation omitted).

Instead, however, this Court has consistently asked whether there was "a specifically identified fund" in the defendant's possession. *U.S. Airways, Inc.* v. *McCutchen*, 133 S. Ct. 1537, 1545 (2013) ("The 'nature of the recovery' requested was equitable because [the plan] claimed 'specifically identifiable funds' within the [beneficiaries]' control—that is, a portion of the settlement they had gotten."); *Sereboff*, 547 U.S. at 363 ("This Court in *Knudson* did not reject Great-West's suit out of hand because it alleged a breach of contract and sought money, but because Great-West did not seek to recover a particular fund from the defendant. Mid Atlantic does."). This is the precise line that effectively prevents converting all relief into compensatory damages, *e.g.*, *Great-West*, 534 U.S. at 210; Respondent's approach would erode that line completely.[3]

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[3] Respondent is incorrect that Mr. Montanile's argument is premised "on a simplistic dichotomy" asking whether relief is sought against "general assets" or "specific property." Br. 28. In traditional practice, different equitable remedies were appropriate in different situations: a surcharge, for example, authorized recovery against general assets *because that reflected the historic nature of that particular claim*. An equitable lien, by contrast, has always been limited to "'particular funds or property in the defendant's possession.'" *Sereboff*, 547 U.S. at 362 (quoting *Great-West*, 534 U.S. at 213). It is *Respondent's* view that proposes a true

2. According to Respondent, "courts in the days of the divided bench" recognized equitable liens over both "the property itself" and "its value," thus entitling parties to pursue a defendant's general assets. Br. 29 (citing *Walker* v. *Brown*, 165 U.S. 564, 666 (1897); 1 George E. Palmer, *The Law of Restitution* § 2.14, at 176 (1978)). This is twice wrong.

Respondent is first wrong because the *bare existence* of an equitable lien (even somehow over intangible "value") does not automatically entitle a party to a "monetary judgment." *Contra* Br. 29. As this Court unmistakably established, there are *two* relevant factors in the inquiry: (i) "the nature of the recovery"; and (ii) "the basis for [the] claim." *Sereboff*, 547 at 363. Unless *both* are equitable, a plaintiff cannot recover under 29 U.S.C § 1132(a)(3). Thus even if the lien were somehow over "value" (whatever that means), Respondent would still have to identify the particular asset in Mr. Montanile's possession. *Contra* Br. 29-30 (wrongly collapsing the inquiry into a single question—whether an equitable lien exists, irrespective of the nature of the requested recovery).

Respondent is wrong a second time because its assertion distorts controlling precedent, including *Walker*, its lead authority. *Walker* never said that a plaintiff could simply establish its lien and then seek the equivalent of monetary damages. Br. 18, 29. On the

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"simplistic dichotomy," one this Court has already rejected: it is not enough to ask whether an equity court had ever granted a particular kind of relief, *contra* Br. 36-44, because "there were many situations . . . in which an equity court could 'establish purely legal rights and grant legal remedies which would otherwise be beyond the scope of its authority.'" *Mertens*, 508 U.S. at 256 (citation omitted).

contrary, *Walker* involved a situation where the specific property at issue—a set of bonds—was "admittedly in the hands" of the relevant party. 165 U.S. at 674-75. The Court had no occasion to address Respondent's theory, because the plaintiff there did what Respondent has failed to do here: identify the property subject to the lien. *Ibid.* Moreover, the *Walker* plaintiff, again unlike Respondent, *admitted* that it needed to identify the bonds, trace the proceeds ("value") from any sale of the bonds, or simply recover as a general creditor to the estate. *Id.* at 659 ("the lien was therefore operative upon the bonds in his possession or upon their proceeds if he had disposed of them, and if the proceeds could be traced to his estate, and if not that the estate was liable for the debt").

That effectively concedes—in a contemporary period—what Respondent refuses to concede here: liens cannot be enforced in equity without identifying the specific property subject to the lien or tracing that property to its clear proceeds. Unsurprisingly, in reciting the controlling "legal principles," that is exactly what the Court said: "It is clear that if the express intention of the parties was to create an equitable lien upon the bonds or the value thereof such equitable lien will be enforced by a court of equity *against the bonds in the hands of [defendant] or against third persons who are volunteers or have notice*." *Id.* at 664 (emphasis added); *see also id.* at 665 (quoting authority as holding that "an equitable lien is enforceable *against the property*") (emphasis added).

This says absolutely nothing about imposing a money judgment directly against the defendant simply because a lien exists (a mere predicate question) or simply because the defendant once had possession of the bonds (an insufficient factor in the analysis). Present

possession is required. *See, e.g.*, *McCutchen*, 133 S. Ct. at 1545; *Sereboff*, 547 U.S. at 362-63; *Great-West*, 534 U.S. at 213. In plucking the "value" phrase out of context, Respondent ignores every relevant feature of this case.[4]

Respondent likewise plucks the same language out of context in *Sereboff*. Br. 19. That language appeared in the section of the Court's opinion asking whether the claim had an equitable basis, not whether the relief was equitable in nature. *See* 547 U.S. at 363-68. The two ideas are analytically distinct, which is precisely why the Court analyzed the issues separately. *See also id.* at 364 (construing *Barnes* v. *Alexander*, 232 U.S. 117, 123 (1914), as authorizing a plaintiff to "'follow' a portion of the recovery 'into the [Sereboffs'] hands' 'as soon as [the settlement fund] was identified,' and impose *on that portion*"—not the defendants' assets generally—"a constructive trust or equitable lien") (emphasis added). In short, if Respondent's theory is right, this Court's decisions are wrong.[5]

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[4] Respondent faults Mr. Montanile for "attempt[ing] to apply unjust-enrichment principles to an action that does not sound in unjust enrichment," supposedly "the very thing that this Court warned against in *McCutchen*." Br. 33. Respondent's argument is premised on a clear logical error: The fact that unjust enrichment is not the same in *all* respects does not mean it is not the same in *any* respects. And, indeed, *McCutchen* specifically *rejects* Respondent's understanding of this Court's case law: "[t]he 'nature of the recovery' requested was equitable because Mid Atlantic claimed 'specifically identifiable funds,' within the Sereboffs' control." 133 S. Ct. at 1545.

[5] Respondent maintains that four other cases support its position, Br. 30-32, but Respondent misreads those cases. Among other things, *none* involves an equitable lien by agreement.

3. If Respondent's view were correct, traditional equitable relief would have been far simpler: there would have been no need to trace the disposition of assets, or establish "substitutionary" remedies, or attach accounts with "mingled" funds, or attempt any of the other machinations that Respondent now proposes (for the first time) as alternative grounds for seeking affirmance.[6] Parties would simply identify an equitable lien by agreement, assert that the beneficiary had previously received the funds, and demand a monetary judgment for the claimed amount. Yet that is decidedly *not* how equitable doctrine works, which is precisely why courts have assiduously demanded that parties identify the precise property or fund in question, or the precise proceeds traceable to that original property.

In the end, Respondent's theory is unsupportable in law and logic, and it has no basis in common experience or common sense. Under Respondent's view, courts and parties have wasted countless hours and resources identifying particular funds and tracing assets, when all that was necessary was identifying the lien in the first place. If Respondent were right, surely more courts would have said so before now—and surely fewer courts (*Sereboff* and *Great-West* included) would have engaged in the make-work of searching for the concrete object of a lien.

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[6] Respondent's "swollen assets" gambit, Br. 33-35, for example, would swallow the rule. If accepted, there would be virtually no cases (contrary to obvious experience) where equitable liens could not be enforced directly, as damages, against a party's general assets. Respondent's assortment of law-review "Note[s]" and "Comment[s]," Br. 33, 35, hardly establish what relief was "*typically* available in equity." *CIGNA*, 131 S. Ct. at 1878 (internal quotation marks omitted).

II. Respondent's Newly Minted Remedies Do Not Provide an Alternative Basis to Affirm.

Respondent's principal defense of the decision below is on alternative grounds. Br. 36-46. As previously explained by Petitioner and the United States, however, neither of Respondent's newly minted remedies is equitable. Pet. Br. 36-42; U.S. Br. 21-26. And, if viable and not already waived, either would require reversal and remand for further litigation.

A. Respondent's Newly Minted Remedies Do Not Constitute Equitable Relief.

In *Mertens* v. *Hewitt Associates*, this Court rejected the notion that any relief a pre-merger equity court might award is equitable. 508 U.S. at 256-58. Under the clean-up doctrine, equity courts frequently awarded legal relief that was a natural incident to the equitable disputes before the court. U.S. Br. 21-22. Both of Respondent's new remedies—the deficiency judgment and substitutionary-monetary decree—fall into that category.

1. The deficiency decree is clearly a legal remedy. Indeed, the very source that Respondent cites (Br. 39, 41, 43) to support the (incorrect) proposition that deficiency decrees are equitable—Pomeroy's treatise—calls the deficiency a "personal debt" that gives rise to a judgment "like every other legal money judgment" and "enforceable by execution against the general property of the judgment creditors." 4 Pomeroy § 1288, at 683.

Respondent also misunderstands the argument that Petitioner and the United States advance. The argument is *not* that deficiency judgments are legal because once upon a time equity courts could not award them. Rather, the argument is that equity courts could not award them *because* they were legal; if deficiency judgments were

always equitable, it would have been unnecessary to enact positive law to *authorize* the new remedy—equity courts would have been issuing the judgments all along. Pet. Br. 38; U.S. Br. 22-23. That States and the Federal Rules of Equity ultimately gave the equity courts *authority* to award a deficiency decree does not convert the *nature* of a deficiency decree, *i.e.*, a legal remedy providing money damages, into equitable relief.

The "substitutionary monetary decrees" invoked by Respondent are legal damages, plain and simple. *See* U.S. Br. 24. When an equitable lien, constructive trust, or other equitable remedy (*e.g.*, specific performance) was unavailable, an equity court might sometimes award "compensation as alternative relief." *Otis* v. *Otis*, 45 N.E. 737, 737 (Mass. 1897). But as the very cases Respondent cites make clear, the decree was legal relief sometimes available in a court of equity. *See, e.g.*, Br. 37 n.6 (citing *Shafer's Appeal*, 2 A. 365, 367 (Pa. 1885)).

Moreover, Respondent identifies no pre-merger equity cases awarding such a decree with an equitable lien by agreement. Instead, the only "substitutionary monetary decree" cases in Respondent's brief involved either tortious conduct or fiduciary breaches by an actual trustee. To be sure, it was not necessarily the defendant in each case who was the tortfeasor or trustee. But in every case, the defendant came into possession of property or funds rightfully belonging to plaintiff because of an earlier tortious act or an earlier fiduciary breach. The defendant dissipated that property or it was otherwise unreachable by tracing. Br. 36-39.

3. Apparently aware that its new remedies fail *Mertens*' "typically available at equity" test, Respondent suggests that *CIGNA* supplanted that test: "Is the

remedy the plaintiff seeks under Section 502(a)(3) 'exclusively equitable'?" Br. 42. It did not.

In *CIGNA*, this Court repeated the familiar "*typically* available in equity" test at the outset of its analysis under 28 U.S.C. § 1132(a)(3), and "exclusively equitable" was not mentioned. 131 S. Ct. at 1878. The Court explained that a "surcharge" was a special equitable remedy that permitted relief in "the form of a money payment." *Ibid.* In underscoring the point, the Court noted, "[i]ndeed, prior to the merger of law and equity this kind of monetary remedy against a trustee . . . was 'exclusively equitable.'" *Id.* at 1880. That kind of passing reference—in the course of a discussion about why a surcharge was still "traditionally equitable relief" (*ibid.*)—is not even close to proposing a "new test" that silently overrules established law.

B. In Any Event, Respondent's New Litigation Position Was Waived or Requires Remand.

1. Respondent insists Petitioner waived his laches argument,[7] Br. 45, but Respondent is the one pressing a new theory for the first time before this Court. Respondent sought recovery under an equitable-lien-by-agreement theory in the lower courts. At no point did

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[7] Petitioner's argument that Respondent waited too long to assert its reimbursement claim has legal significance in two ways, both of which reveal that Petitioner has waived nothing. First, Respondent's decision to wait six months after an exchange of final settlement offers, Pet. Br. 8, before bringing a lawsuit reveals the potential for abuse under Respondent's rule. Second, Respondent's delay is relevant to its ability to recover a deficiency judgment, a remedy that it never even mentioned in the Eleventh Circuit or district court. Petitioner cannot have waived a response to an argument that Respondent made for the first time before this Court.

Respondent mention deficiency judgments or substitutionary-monetary decrees. Instead, Respondent argued at every stage that it was required to "(1) identify a particular fund distinct from the defendant's general assets; and (2) identify a particular share of the fund to which it is entitled" in order to enforce its equitable lien. Appellee's C.A. Br. 25; Pl.'s Summ. J. Mot., ECF No. 36 at 5. And the lower courts agreed: Mr. Montanile's dissipation was entirely irrelevant to Respondent's ability to enforce its equitable lien. Pet. App. 11, 41.

Respondent says "a request for an equitable lien encompasses a request for a substitutionary monetary decree and a deficiency judgment." Br. 45, n.9. But if those remedies were so closely affiliated with with its original theory, at least *some* court would have mentioned them in response to a dissipation argument. But no lower court has so held, and for good reason—these are creative arguments that talented counsel have crafted for the first time before this Court. As such, they are waived. *See, e.g.*, *Roberts* v. *Galen of Virginia, Inc.*, 525 U.S. 249, 253 (1999). *Cf.* Sup. Ct. R. 15.2.

2. If this Court even entertains Respondent's tardy request for relief, it should remand for further proceedings.

If either a deficiency judgment or a substitutionary-monetary remedy constitutes "equitable relief" under 29 U.S.C. § 1132(a)(3), this Court will be the first *ever* to announce that rule. When this Court, for the first time in *CIGNA*, endorsed new equitable remedies (surcharge, reformation, estoppel), it remanded the case for the lower courts to determine the availability of those remedies. 131 S. Ct. at 1882. So too here: the Court should permit the lower courts to determine whether

Respondent qualifies for a deficiency judgment (it will not) or a substitute-monetary remedy (it will not).

As previously explained, to obtain a deficiency judgment, the defendant must possess the property at the time of judgment. A deficiency judgment is awarded only when the sale of property cannot satisfy the debt. Deficiency judgment is unavailable when there is nothing to sell. U.S. Br. 32-33 (citing 1 Pomeroy § 240, at 451-452; *City Bank* v. *Plank*, 124 N.W. 1000, 1003 (Wis. 1910)); Pet. Br. 37. Also, deficiency judgment was refused if the lienholder failed to behave in a commercially reasonable fashion. Pet. Br. 40 n.21 (citing *Pioneer Dodge Center, Inc.* v. *Glaubersklee*, 649 P.2d 28, 30 (Utah. 1982)). That analysis asked whether the lienholder failed to promptly foreclose on the lien. Pet. Br. 39-41 (discussing *Fidelity Deposit Co.* v. *Central Bank*, 48 F.2d 477 (8th Cir. 1931), and citing *Zack* v. *City of Minneapolis*, 601 F. Supp 117, 120 (D. Minn. 1985)). These are fact questions that cannot be decided on this record. Respondent never sought to have Mr. Montanile's funds placed in escrow, so the funds may be entirely dissipated.[8] And while the district court was not persuaded that the Plan's delay barred an equitable lien, its assessment may change with a different remedy under a different standard. *See* Pet. Br. 40-41 (describing the Plan's delay).

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[8] That Mr. Montanile may have been in possession of at least some of the funds at the time of filing suit is important but ultimately insufficient to obtain a deficiency judgment. A plan's equitable lien and deficiency judgment claims will fail at the outset if the property has been dissipated before the suit is filed because there is no property to foreclose on. A substitutionary monetary remedy *may* be available even if there is dissipation before filing, but that reinforces just how separate such a remedy is from equitable lien by agreement.

A substitutionary-monetary decree also requires further litigation—and, in fact, Respondent cannot prevail under the very cases it cites. Each of those cases involves tortious conduct or fiduciary breach. Even if that remedy were available in cases involving equitable liens by agreement, there is no tortious conduct or fiduciary breach in a bona fide dispute over the contract itself. Respondent disparages Mr. Montanile's challenges to the reimbursement claim, but Petitioner carefully explained that this Court had to resolve one issue Mr. Montanile advanced, and the other remains the subject of a circuit split. Pet. Br. 7 n.6, 40 n.22. It is not tortious conduct to fail to predict the right disposition of such difficult questions, and Mr. Montanile is of course not a fiduciary.

III. Respondent's Policy Arguments Are Overblown and Directed at the Wrong Branch.

Faced with an untenable doctrinal position, Respondent defends its legal rule as a matter of policy and "common sense." Br. 2, 46-56. Respondent's view could not be clearer: The Court should "ensure that the Plan's right to reimbursement is not 'without a remedy' under the statute." Br. 4.[9]

As the United States explained, Br. 26-27, Respondent and its amici have offered exactly the same policy and fairness arguments that this Court rejected in *Great-West*. And the sky did not fall (or even darken). In the intervening years, Congress felt compelled to address Respondent's policy concerns with: precisely nothing. *See, e.g.*, U.S. Br. 28-29 (discussing Congress'

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[9] Even Respondent's lead doctrinal arguments look to policy. *See, e.g.*, Br. 26-27 (Section II.A) ("The Decision Below Is Consistent With Time-Honored Maxims of Equity.").

inaction). Nonetheless, given its central role in Respondent's brief, we address Respondent's policy concerns here:

1. Respondent's professed concern about the sanctity of ERISA plan terms is specious. Respondent notes that "[t]his Court has repeatedly emphasized Congress' goal of ensuring that ERISA plans are administered and enforced according to their terms." Br. 46. True. But that hardly proves that all *relief* is available to remedy a breach. Indeed, Respondent surely knows the following:

When a plan fiduciary in bad faith denies an ERISA plan's promised benefits, the affected participant may only recover the value of the denied benefits. 29 U.S.C. § 1132(a)(1)(B). "[E]quitable relief" under 29 U.S.C. § 1132(a)(3) will *never* entitle the aggrieved participant to recover consequential damages, even for an intentional breach and foreseeable injury. *See, e.g.*, Pet. Br. 46-47 (discussing, *inter alia*, Paul M. Secunda, *Sorry, No Remedy: Intersectionality and the Grand Irony of ERISA*, 61 Hastings L.J. 131 (2009)).

Respondent offers no reason why participants should be constrained by this Court's interpretation of 29 U.S.C. § 1132(a)(3) but fiduciaries should escape so "'equity suffers not a right to be without a remedy.'" Br. 26 (quoting *CIGNA*, 131 S. Ct. 1866, 1879 (2011)) (quoting Richard Francis, *Maxims of Equity* 29 (1st Am. Ed. 1823)).[10] That is unsurprising. No reason exists.

2. Respondent is wrong that tracing rules "burden beneficiaries, plans, and courts," Br. 46, and its concerns illustrate vividly why Congress, and not the courts, set policy:

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[10] *CIGNA* did not change this reality for participants.

First, Respondent speculates wildly that (i) the availability of ERISA remedies affects the likelihood that participants will breach reimbursement provisions, *compare* Br. 48-55, *with* Pet. Br. 42-44, and (ii) fiduciaries will otherwise be unable to protect their reimbursement rights, *compare* Br. 55-56, *with* Pet. Br. 44-45; U.S. Br. 29-31.

The parties' good-faith disagreement should end the inquiry. This is precisely the type of empirical question that legislators must study in setting policy. It falls outside the judiciary's proper role and core competency. For that reason, this Court in *Great-West* expressly rejected the exact same arguments advanced by Respondent and its amici here. Indeed, Respondent's amici appear to have rehashed portions their *Great-West* briefs nearly verbatim:

AMICUS BRIEFS OF THE SELF INSURANCE INSTITUTE OF AMERICA

Great-West	***Montanile***
"[P]lan sponsors would be encouraged to defer or delay payment of claims for medical expenses related to third party negligence until the accident liability issues have been fully resolved or until after third party litigation has been terminated" Br. 9.	"[P]lan providers . . . could elect to defer or delay payment of claims for medical expenses related to another party's negligence until the accident liability issues have been fully resolved or until litigation has concluded" Br. 30.

"Plan sponsors are likely to amend their plans to exclude coverage for medical expenses related to negligent third-party" Br. 9.	"[P]lan sponsors might be compelled to amend their plans to exclude coverage for medical expenses related to the negligence of other parties" Br. 30.

AMICUS BRIEFS OF MULTI-EMPLOYER PLANS

Great-West	*Montanile*
"[This] will result in the nonuniform enforcement of plans[and] an increase in administrative costs for plans . . . all to the detriment of plan beneficiaries." Br. 2-3.	"The result of losing a uniform equitable remedy in the federal courts will be increased administrative costs . . and a concomitant reduction in benefits for . . beneficiaries." Br. 27.

AMICUS BRIEFS OF THE NATIONAL ASSOCIATION OF SUBROGATION PROFESSIONALS

Great-West	*Montanile*
"[This will result] in a reduction in health care benefits for all plan participants or a significant increase in costs for the participant." Br. 2.	"[E]mployers may be forced to reduce or eliminate certain benefits, increase premiums, or do both . . . ." Br. 29.

Plan fiduciaries will predict the same parade of horribles every time they face a possible limit on pursuing reimbursement claims. Whether those concerns are legitimate or warrant legislative change are questions for Congress to decide. In any event, plan fiduciaries have thrived for nearly fifteen years in the current legal environment. U.S. Br. 29-30.

Second, Respondent focuses on purported benefits of its preferred policy (reducing non-compliance and lowering plan costs) while overlooking predictable costs that a fair-minded policymaker might wish to avoid.

As previously explained, the question presented here affects not only subrogation but *every* type of ERISA benefit, including pension and disability insurance. *See* Pet. 7-8. There are compelling policy reasons to disfavor Respondent's proposed rule in those other settings. *See, e.g.*, Br. of AARP 6-15 (Respondent's rule causes grossly unfair results in the pension-overpayment context); Br. of United Policyholders 6-15 (Respondent's rule is grossly unfair in the disability-insurance context and functions as an industry end-run around Congress' anti-alienation provision in the Social Security Act).

Conspicuously absent from Respondent's brief is any mention of these other contexts. That is telling given that a majority of decisions constituting the current circuit conflict arises outside the subrogation context.

In short, the proper scope of ERISA is a policy determination for the political branches. This Court has construed (repeatedly) the controlling terms of that statute, and its consistent construction compels reversal.

CONCLUSION

For the reasons set forth above, the judgment of the Eleventh Circuit should be reversed and the case remanded for further proceedings.

Respectfully submitted,

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No. 14-723

In the Supreme Court of the United States

ROBERT MONTANILE, PETITIONER

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Section 502(a)(3) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1132(a)(3), allows a plan participant, beneficiary, or fiduciary to obtain an injunction or "other appropriate equitable relief" to redress statutory violations or to enforce ERISA or the terms of the plan. The question presented is:

Whether an action by an ERISA fiduciary against a plan participant to recover an overpayment by the plan seeks "equitable relief" within the meaning of ERISA Section 502(a)(3), 29 U.S.C. 1132(a)(3), where the fiduciary has not identified a particular fund that is in the participant's possession and control at the time that the fiduciary asserts its claim.

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In the Supreme Court of the United States

No. 14-723

ROBERT MONTANILE, PETITIONER

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

INTEREST OF THE UNITED STATES

The question presented in this case concerns the scope of "appropriate equitable relief" available in a civil action by a plan fiduciary under Section 502(a)(3) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1132(a)(3). The Secretary of Labor has primary authority for administering Title I of ERISA.

STATEMENT

1. Petitioner was a participant in the National Elevator Industry Health Benefit Plan (the Plan), an employee welfare plan governed by ERISA and administered by respondent. Pet. App. 2-3. The Plan, which afforded health-care benefits to participants, provided that respondent had "the right to recover

benefits advanced by the Plan to a covered person for expenses or losses caused by another party."[1] *Id.* at 22. The Plan further provided that "[a]mounts that have been recovered by a covered person from another party are assets of the Plan by virtue of the Plan's subrogation interest and are not distributable to any person or entity without the Plan's written release of its subrogation interest." *Ibid.*

In December 2008, petitioner was injured in a car accident. Pet. App. 6. The Plan paid petitioner's initial medical expenses of $121,044.02. *Ibid.* Petitioner sued the driver of the other car and obtained a $500,000 settlement. *Ibid.* Respondent then attempted to recover from petitioner the medical expenses the Plan had paid. *Id.* at 7. Between June 2011 and January 2012, respondent and petitioner engaged in negotiations concerning whether the Plan's provisions gave respondent a right to reimbursement, and if so, the amount respondent was owed. *Ibid.* When negotiations broke down in January 2012, petitioner's counsel informed respondent that he would disburse the funds received in the settlement to petitioner in 14 days. J.A. 35. In February 2012, having received no response, petitioner's counsel disbursed the funds. *Ibid.*

2. In July 2012, respondent filed this suit under ERISA Section 502(a)(3), seeking reimbursement of the medical expenses paid by the Plan. Section 502(a)(3) authorizes a plan fiduciary to bring a civil action "to obtain * * * appropriate equitable relief

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[1] The relevant provisions are contained in a summary plan description that the court of appeals concluded was a "governing Plan document" containing "enforceable plan terms." Pet. App. 16-17. Petitioner does not challenge that ruling. See *US Airways, Inc.* v. *McCutchen*, 133 S. Ct. 1537, 1541 n.1 (2013).

* * * to enforce any provisions of [ERISA] or the terms of the plan." 29 U.S.C. 1132(a)(3)(B)(ii); Pet. App. 24-25. Respondent alleged that "all or part of the settlement proceeds are within the actual or constructive possession of [petitioner]" and claimed that the Plan was "entitled to equitable restitution in the form of a constructive trust or equitable lien with respect to the disputed funds held in [petitioner's] actual or constructive possession." Pet. App. 7.

Respondent moved for summary judgment, relying on *Sereboff* v. *Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), which held that a fiduciary seeks "equitable relief" within the meaning of Section 502(a)(3) when it seeks to enforce an equitable lien by agreement against "specifically identifiable funds"—*i.e.*, those funds recovered from a third party—that are "within the possession and control" of the participant or beneficiary. *Id.* at 362-363 (citation and internal quotation marks omitted). Petitioner cross-moved for summary judgment, arguing, among other things, that he no longer possessed the settlement funds. Pet. App. 8. Under *Great-West Life & Annuity Insurance Co.* v. *Knudson*, 534 U.S. 204 (2002), petitioner contended, a fiduciary may not enforce an equitable lien when the relevant funds are not in the beneficiary's possession. In that situation, petitioner maintained, a claim for reimbursement seeks legal relief because it seeks recovery from the beneficiary's general assets. Pet. App. 8.

The district court held that respondent was entitled to reimbursement for the full amount of the medical costs it had provided to petitioner. Pet. App. 19-45. The court reasoned that the Plan's terms created an equitable lien by agreement in any third-party recov-

ery petitioner received, and "a beneficiary's dissipation of assets is immaterial when a fiduciary asserts an equitable lien by agreement." *Id.* at 40.

3. The court of appeals affirmed, Pet. App. 1-18, concluding that this case was controlled by its recent decision in *AirTran Airways, Inc.* v. *Elem*, 767 F.3d 1192 (2014), petition for cert. pending, No. 14-1061 (filed Feb. 27, 2015). Pet. App. 10-11. In *AirTran*, the court of appeals held that where a plan provision gave the plan a first-priority claim to all payments made by a third party, an equitable lien attached to any settlement funds the beneficiary received. 767 F.3d at 1198. In the court's view, the beneficiary's subsequent dissipation of the funds "could not destroy the lien that attached *before*" the dissipation. *Ibid.* The court based that conclusion on *Sereboff*, which held that a fiduciary "need not trace the settlement fund back to [the fiduciary] to enforce its equitable lien." *Ibid.*

The court of appeals distinguished *Great-West*, which had held that the fiduciary sought legal relief because the funds subject to the lien were not in the beneficiary's possession, on the ground that the beneficiary in *Great-West* had "never possessed the settlement fund" because it had been placed directly in a special needs trust. *AirTran*, 767 F.3d at 1198.

SUMMARY OF ARGUMENT

Section 502(a)(3) of ERISA authorizes "appropriate equitable relief * * * to enforce * * * the terms of [an ERISA] plan." 29 U.S.C. 1132(a)(3). This Court's decisions and traditional principles of equity establish that an ERISA fiduciary may use Section 502(a)(3) to obtain reimbursement from a beneficiary only if the fiduciary seeks to enforce an equitable lien or constructive trust against identified funds that remain in

the beneficiary's possession and control at the time of suit.

I. In *Great-West Life & Annuity Insurance Co.* v. *Knudson*, 534 U.S. 204 (2002), this Court held that Section 502(a)(3) does not permit a fiduciary to obtain legal damages against a plan participant or beneficiary who has failed to reimburse the plan for medical expenses paid by the plan and later recovered from a third party. *Id.* at 207. To seek relief that qualifies as "equitable" under Section 502(a)(3), the fiduciary must assert an equitable lien or constructive trust against identified funds in the beneficiary's possession—namely, the funds recovered from the third party. *Id.* at 213-214 (citation omitted). If the beneficiary has "dissipated [the recovery] so that no product remains," the fiduciary can no longer "enforce a constructive trust or an equitable lien" against those funds. *Ibid.* In that situation, any pecuniary award would come out of the beneficiary's general assets and would constitute legal relief not authorized by Section 502(a)(3). *Ibid.*

Accordingly, because the beneficiary in *Great-West* did not possess the funds in question—they had been disbursed to a special needs trust—the Court held that the fiduciary could not recover under Section 502(a)(3). The Court reaffirmed that understanding of "equitable relief" in *Sereboff* v. *Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), in which it held that the fiduciary could assert an equitable lien under Section 502(a)(3) because the funds in question remained in the beneficiaries' possession.

Great-West and *Sereboff* thus establish that a fiduciary may assert an equitable lien only against identified funds in the plan participant's possession at the

time of suit. That conclusion is reinforced by the traditional equitable principles on which this Court has relied in construing Section 502(a)(3). At equity, an equitable lien or constructive trust was understood to be an interest in particular property, rather than a right to a money judgment against the defendant's general assets. 4 John Norton Pomeroy, *A Treatise on Equity Jurisprudence* § 1234, at 694 (Spencer W. Symons ed., Bancroft-Whitney Co. 5th ed. 1941) (1883) (*Pomeroy*). If the defendant dissipated the property, the lien or trust could no longer be enforced. 1 Restatement of Restitution § 161 cmt. e, at 653 (1937) (Restatement); *id.* § 160 cmt. g, at 648.

Respondent argues that equity courts could award monetary relief in the form of a deficiency judgment or damages when the property subject to a lien had been partially or wholly dissipated. But those remedies were understood to be legal, not equitable, relief that an equity court could award as a matter of ancillary jurisdiction. This Court has explained that "equitable relief" under Section 502(a)(3) does not include the legal remedies a court of equity was "empowered to provide in the particular case at issue." *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 256 (1993).

Permitting a fiduciary to enforce an equitable lien only against identified third-party recovery funds in the defendant's possession is consistent with ERISA's design. To be sure, in some cases, the beneficiary's disposition of the funds will prevent the fiduciary from recovering the reimbursement to which it is entitled. But that possibility has been clear since *Great-West*, and Congress has not acted to override this Court's construction of Section 502(a)(3) in reimbursement cases. In addition, fiduciaries have adopted several

practices designed to protect their rights to reimbursement, including pursuing third-party recoveries as subrogee of the beneficiary's claims, or restraining the beneficiary's disposition of any recovery obtained.

II. Even if this Court were to conclude that the monetary remedies respondent proposes are "equitable relief" under Section 502(a)(3), respondent would not be entitled to relief unless it can satisfy those remedies' prerequisites. At equity, courts awarded deficiency judgments only when the defendant still possessed some property subject to the lien, and they awarded damages only when the defendant had disposed of the property in bad faith. Because respondent did not press those theories below, a remand would be necessary to permit the lower courts to address them in the first instance.

ARGUMENT

I. A FIDUCIARY MAY NOT OBTAIN REIMBURSEMENT UNDER SECTION 502(a)(3) WHEN THE BENEFICIARY NO LONGER POSSESSES THE FUNDS RECOVERED FROM A THIRD PARTY

The court of appeals erred in holding that ERISA Section 502(a)(3) allows a plan fiduciary to recoup payments from a participant or beneficiary who has received a third-party tort recovery regardless of whether the participant still possesses those funds. This Court's decisions in *Great-West* and *Sereboff*, as well as traditional equitable principles, establish that a fiduciary seeks "equitable relief" within the meaning of Section 502(a)(3) if it asserts an equitable lien by agreement against identified funds or property in the beneficiary's possession and control at the time of suit. But where the funds are no longer in the beneficiary's possession, the fiduciary's claim is one for

reimbursement out of the beneficiary's general assets—in other words, it is a claim for legal damages rather than "equitable relief" under Section 502(a)(3). Although the beneficiary's disposition of recovered funds may thus prevent the fiduciary from obtaining reimbursement in some cases, since *Great-West*, fiduciaries have mitigated the potential unfairness of that result by employing a number of methods.

A. This Court's Precedents Establish That Section 502(a)(3) Permits A Fiduciary To Assert An Equitable Lien Or Constructive Trust Against Identified Funds Or Property In The Beneficiary's Possession, But Does Not Permit An Award Of Legal Damages Against The Beneficiary's General Assets

1. This Court has held that an equitable lien or constructive trust may be enforced only when the identified funds are in the beneficiary's possession

a. In *Mertens* v. *Hewitt Associates*, 508 U.S. 248 (1993), this Court construed Section 502(a)(3)'s provision for plan participants, beneficiaries, and fiduciaries to seek appropriate "equitable relief" to enforce the terms of an ERISA plan. The Court held that a claim by plan participants against a non-fiduciary third party who provided services to a plan, seeking "monetary relief for all losses their plan sustained as a result of the alleged breach of fiduciary duties," did not seek "equitable relief." *Id.* at 255. In substance, the Court explained, the plaintiffs sought "[m]oney damages" compensating for the plan's losses—in other words, "the classic form of *legal* relief." *Ibid.*

The Court held that "equitable relief" under Section 502(a)(3) includes only "those categories of relief that were *typically* available in equity (such as injunc-

tion, mandamus, and restitution, but not compensatory damages)." *Mertens*, 508 U.S. at 256. The Court rejected the argument that legal damages could be considered relief "typically available in equity" because an equity court could in certain circumstances award damages. *Ibid.* (emphasis omitted). The Court recognized that "there were many situations * * * in which an equity court could 'establish purely legal rights and grant legal remedies which would otherwise be beyond the scope of its authority.'" *Id.* at 256 (quoting 1 *Pomeroy* § 181, at 257); see also 1 *Pomeroy* § 231, at 410. But the Court concluded that if Section 502(a)(3) permitted courts to award "whatever [legal] relief a court of equity is empowered to provide in the particular case at issue," *Mertens*, 508 U.S. at 256, Congress's provision that the relief must be "equitable" would cease to have meaning, *id.* at 257.

b. The Court has twice applied the principles set forth in *Mertens* to a fiduciary's attempt to enforce a plan reimbursement provision against a plan participant or beneficiary who received medical benefits following an injury.

i. In *Great-West*, the Court determined that Section 502(a)(3) did not permit a reimbursement action against a plan beneficiary who received medical benefits following a car accident. 534 U.S. at 207. The beneficiary had obtained a recovery in a tort settlement with third parties, and the plan's terms gave the plan a right to reimbursement out of that recovery. After the fiduciary's effort to obtain a temporary restraining order (TRO) preventing dissipation of the settlement funds was unsuccessful, see *id.* at 226 (Ginsburg, J., dissenting), the funds were disbursed. One portion went directly into a special needs trust

for the beneficiary, and another went to the participant's attorney, who deducted his own fees and used the remainder to pay the beneficiary's other creditors. *Id.* at 214.

In rejecting the fiduciary's argument that it sought "equitable relief" in the form of restitution, the Court explained that restitution can be either legal or equitable, depending upon the basis for the claim and the nature of the underlying remedies sought. *Great-West*, 534 U.S. at 212-213 (citations omitted). A "plaintiff could seek restitution *in equity*, ordinarily in the form of a constructive trust or an equitable lien, where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession." *Id.* at 213. But where the plaintiff did not seek to impose a constructive trust or equitable lien on particular funds or property in the defendant's possession, the Court explained, the suit did not seek equitable relief, but instead sought "the imposition of personal liability," a legal remedy. *Id.* at 214.

The Court further noted that "where 'the property [sought to be recovered] or its proceeds have been dissipated so that no product remains, [the plaintiff's] claim is only that of a general creditor,' and the plaintiff 'cannot enforce a constructive trust or an equitable lien upon other property of the [defendant].'" *Great-West*, 534 U.S. at 213-214 (brackets in original) (quoting Restatement § 215 cmt. a, at 867). Because the settlement funds in *Great-West* were not in the beneficiary's possession, the Court held that the fiduciary sought, "in essence, to impose personal liability on [the participant] for a contractual obligation to pay money—relief that was not typically available in equi-

ty," and thus not available under ERISA Section 502(a)(3). *Id.* at 210; see *CIGNA Corp.* v. *Amara*, 131 S. Ct. 1866, 1878-1879 (2011).

ii. Subsequently, in *Sereboff*, the Court addressed a claim for reimbursement where the beneficiaries had placed the portion of their tort recovery claimed by the plan in an investment account pending resolution of the reimbursement dispute. 547 U.S. at 360. The Court explained that to qualify as "equitable relief" under Section 502(a)(3), a claim must fulfill two requirements: (1) the remedy sought must be equitable in nature, and (2) the "basis for [the] claim" must also be equitable. *Id.* at 363 (citing *Great-West*, 534 U.S. at 213). With respect to the latter requirement, the Court held that basis for the fiduciary's claim was equitable because the fiduciary sought to enforce an "equitable lien 'by agreement'" based on plan terms identifying a specific fund (*i.e.*, any third-party recovery received by the beneficiary) to which the fiduciary was entitled. *Id.* at 364-365 (citation omitted).

With respect to the equitable-remedy requirement, the Court held that because the beneficiaries, unlike the beneficiary in *Great-West*, possessed the particular funds in question, the "impediment to characterizing the relief in [*Great-West*] as equitable is not present." *Sereboff*, 547 U.S. at 362. Although the fiduciary in *Sereboff*, like the fiduciary in *Great-West*, "alleged breach of contract and sought money," its claim was directed to "'specifically identifiable funds' that were 'within the possession and control of the [beneficiaries]—that portion of the tort settlement due [the fiduciary] under the terms of the ERISA plan, set aside and 'preserved' [in the beneficiaries'] investment accounts." *Id.* at 362-363 (citation omitted). The fidu-

ciary's claim could therefore be characterized as seeking "recovery through a constructive trust or equitable lien on a specifically identified fund, not from the [beneficiaries'] assets generally, as would be the case with a contract action at law." *Id.* at 363; see *US Airways, Inc.* v. *McCutchen*, 133 S. Ct. 1537, 1544-1545 (2013) (the "nature of the recovery" requested in *Sereboff* was "equitable because [the fiduciary] claimed 'specifically identifiable funds' within the [beneficiaries'] control").

c. *Great-West* and *Sereboff* thus make clear that a claim seeking monetary relief for a beneficiary's breach of plan terms must be directed at particular funds or property in the defendant's possession. Otherwise, the plan would be seeking reimbursement from the beneficiary's general assets. That relief is legal, not equitable, in nature. *Great-West*, 534 U.S. at 213-214; *Sereboff*, 547 U.S. at 362-363.

In this case, petitioner asserts that he no longer possesses the bulk of the third-party tort settlement he received. Pet. Br. 9; see Pet. App. 35 n.2.[2] Under *Great-West*, respondent may seek to enforce an equitable lien or constructive trust only against the portion of the recovery (if any) that petitioner still possesses. To the extent the "property * * * or its proceeds have been dissipated so that no product remains," respondent may not "enforce a constructive trust of or an equitable lien upon other property of"

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[2] As the district court explained, the record does not reveal how much, if any, of the settlement funds petitioner still possesses. Pet. App. 35-36 & n.2. Petitioner asserted that after making various payments, he was left with "approximately $90,000," most of which he spent on living expenses. *Id.* at 36. Respondent disputes the accuracy of that account.

petitioner. *Great-West*, 534 U.S. at 213-214 (citation omitted). The Court reaffirmed that principle in *Sereboff*, explaining that where, as here, the "particular fund" identified by the fiduciary has been dissipated, the fact that the fiduciary would have to seek reimbursement from the beneficiary's general assets creates an "impediment to characterizing the relief * * * as equitable." 547 U.S. at 362-363.

2. Respondent's attempts to avoid the import of Great-West *and* Sereboff *are unpersuasive*

In its effort to avoid the force of *Great-West* and *Sereboff*, respondent reiterates the arguments on which the court of appeals relied in *AirTran Airways, Inc.* v. *Elem*, 767 F.3d 1192 (11th Cir. 2014). Those arguments lack merit.

a. Respondent first relies on the Court's statement in *Sereboff* that the plan's "inability to satisfy the 'strict tracing rules' for 'equitable restitution' is of no consequence," 547 U.S. at 365 (citation omitted). See Br. in Opp. 17; *AirTran*, 767 F.3d at 1198. That statement, respondent argues, negates the need to identify specific funds in the beneficiary's possession against which an equitable lien can be enforced. In respondent's view, so long as the beneficiary possessed the funds at some point, "the beneficiary's promise will be enforced in equity," even if the funds can no longer be "traced" because the beneficiary has spent them. Br. in Opp. 17.

Respondent misunderstands *Sereboff*'s discussion of the equitable-tracing rule at issue in that case. The beneficiaries in *Sereboff* claimed that an equitable lien could not be enforced unless the fiduciary could "trace" the identified funds in the beneficiaries' possession back to property that had been *in the ERISA*

plan's possession when the beneficiaries had wrongfully appropriated it. 547 U.S. at 364 (citation omitted). In rejecting that argument, the Court explained that an "equitable lien was imposed as restitutionary relief" in several different situations, one of which involved misappropriation—namely, a claim that "an asset belonging to the plaintiff had been improperly acquired by the defendant." *Ibid.* When a plaintiff asserted an equitable lien based on misappropriation, he was required to demonstrate that the property in the defendant's possession could be "trace[d]" to property originally held by the plaintiff. *Id.* at 364-365. By contrast, a fiduciary's claim for reimbursement required by plan terms is based on a "different species" of equitable lien: an "equitable lien 'by agreement'" that arises out of the beneficiary's contractual promise to reimburse the plan out of any third-party recovery. *Id.* at 365 (citation omitted); see *id.* at 364. An equitable lien by agreement, the Court explained, was traditionally not subject to the requirement that the property in the defendant's possession be traceable to the plaintiff because the property in question might have been transferred to the defendant by a third party. *Id.* at 365. The Court therefore concluded that it would be inappropriate to impose a tracing requirement "of the sort asserted by the [beneficiaries]" in the context of a reimbursement suit by a fiduciary. *Ibid.*

The Court's rejection of the tracing requirements applicable to equitable liens based on misappropriation does not suggest that the Court abandoned the requirement—applicable to equitable liens generally —that the lien may be enforced only against identified funds in the defendant's possession. To the contrary,

the Court had just reaffirmed *Great-West*'s holding that for reimbursement relief to be equitable in nature, the plan must identify funds in the beneficiary's possession against which the lien could be enforced. *Sereboff*, 547 U.S. at 362-363. And the Court had just distinguished *Great-West* on the ground that the Sereboffs, unlike the participant in *Great-West*, retained possession of the funds at issue. *Ibid.* It is exceedingly unlikely that the *Sereboff* Court immediately followed those admonitions with (as respondent would have it) directly contrary reasoning that would permit a plan to pursue recovery out of the beneficiary's general assets when the beneficiary has already spent the specific funds in question.

b. Respondent, like the court of appeals, seeks to distinguish *Great-West* on the ground that there the beneficiary never possessed the settlement fund, "so the lien never attached to anything held by the beneficiary. Br. in Opp. 18; see *AirTran*, 767 F.3d at 1198. In this case, respondent argues, "the lien * * * attached" when the funds came into petitioner's possession, and therefore the lien must be enforceable without regard to whether the funds are still in petitioner's possession. Br. in Opp. 18. That argument is refuted by *Great-West* and the equity authorities on which it relied.

The Court in *Great-West* never suggested that the dispositive consideration was that the beneficiary had never possessed the funds. Rather, *Great-West* relied on the fact that the funds "*are not* in [the beneficiaries'] possession." 534 U.S. at 214 (emphasis added). For purposes of characterizing the plan's claim as either legal or equitable, what mattered was whether the beneficiaries "hold [the] particular funds." *Ibid.*

Because the beneficiaries did not hold the funds at the time the fiduciary sought to enforce the lien, there was no property against which that lien could be enforced. *Ibid.* The Court reaffirmed that conclusion in *CIGNA*, stating that "relief that sought a lien or a constructive trust was legal relief, not equitable relief, unless the funds in question were '*particular* funds or property in the defendant's possession.'" 131 S. Ct. at 1879 (quoting *Great-West*, 534 U.S. at 213). The equitable authorities on which *Great-West* relied reinforce the point, explaining that an equitable lien cannot be enforced when the defendant "once had property" subject to the lien but then "dissipate[d]" it. Restatement § 215 cmt. a, at 866; see pp. 18-21, *infra*.

c. Finally, respondent contends (Br. in Opp. 18) that *Great-West* "dealt only with equitable restitution," that "equitable restitution" and "equitable liens by agreement" are categorically different types of relief, and that *Sereboff* established that any "present-possession" requirement recognized in *Great-West* does not apply to equitable liens by agreement. *Id.* at 17. Respondent is incorrect.

As *Sereboff* explained, to qualify as "equitable relief" under Section 502(a)(3), the remedy sought must be equitable in nature, and the "basis for [the] claim" must also be equitable. 547 U.S. at 363. *Great-West*'s discussion of the "present-possession" requirement pertained to the equitable-remedy element. 534 U.S. at 213. A claim for monetary reimbursement qualifies as an equitable remedy if it can be characterized as "restitution *in equity*"—*i.e.*, if the plaintiff seeks to enforce an equitable lien or constructive trust against "particular funds or property in the defendant's possession." *Ibid.*

Sereboff then elaborated on the requirement that the "basis for [the] claim" must be equitable. 547 U.S. at 363. The Court explained that there are multiple "claim[s]" or theories that could underlie a request for an equitable lien, distinguishing between an "equitable lien sought as a matter of restitution" (*i.e.*, where the defendant has misappropriated the plaintiff's property) and "an equitable lien 'by agreement,'" (*i.e.*, where the defendant has breached an agreement). *Id.* at 363-365. In rejecting the beneficiary's argument that the tracing rules for equitable liens based on misappropriation should apply to plan reimbursement claims, *Sereboff* clarified that the type of claim asserted by an ERISA fiduciary seeking reimbursement is an equitable lien by agreement. *Id.* at 364-365. *Sereboff* further explained that *Great-West* had addressed only the equitable-remedy aspect of the analysis and had not implicitly held that plan reimbursement claims are subject to the requirements for equitable liens based on misappropriation. *Id.* at 365; but cf. Br. in Opp. 18.

Sereboff did not suggest, as respondent contends, that *Great-West*'s present-possession requirement disappears when a fiduciary asserts an equitable lien by agreement. It is true that when a fiduciary seeks to enforce an equitable lien by agreement, it has asserted an equitable "basis for its claim"; but it must then also establish that it seeks an equitable remedy—in other words, that it seeks reimbursement from specified funds in the beneficiary's possession. *Sereboff*, 547 U.S. at 363, 365. *Sereboff* made that clear by applying the present-possession requirement to the fiduciary's claim based on an equitable lien by agreement. *Id.* at 362.

B. Traditional Principles Of Equity Confirm That An Equitable Lien Is Enforceable Only Against Identified Funds In The Defendant's Possession

The conclusion that a fiduciary may enforce an equitable lien or constructive trust only against identified funds in the beneficiary's possession is reinforced by the principles of equity to which this Court has looked when analyzing the types of relief available under ERISA Section 502(a)(3). See, *e.g.*, *Sereboff*, 547 U.S. at 362-363; *Great-West*, 534 U.S. at 213-214; *Mertens*, 508 U.S. at 256.

1. An equitable lien or constructive trust must be enforced against particular property in the defendant's possession

a. An equitable lien "constitutes a charge or encumbrance upon [a particular] thing, so that the very thing itself may be proceeded against in an equitable action, and either sold or sequestered under a judicial decree," with the proceeds "applied upon the demand of the creditor in whose favor the lien exists." 4 *Pomeroy* § 1233, at 692. That general rule holds when the equitable lien is established by agreement: the contract in question "recognizes, *in addition to the personal obligation*, a peculiar right over the thing concerning which the contract deals." *Id.* § 1234, at 695. When an agreement establishes such a right, "the plaintiff is enabled to follow the identical thing, and to enforce the defendant's obligation by a remedy which operates directly upon that thing." *Ibid.*

At equity, it followed from those general principles that an "equitable lien [could] be established and enforced only if there [was] some property which [was] subject to the lien." Restatement § 161 cmt. e, at 652. The authorities thus emphasized that "[i]t is

essential to an equitable lien that the property to be charged should be capable of identification." 1 Leonard A. Jones, *A Treatise on the Law of Liens* § 34, at 24 (rev. 2d ed. 1894) (*Jones*); see 4 *Pomeroy* § 1234, at 695 ("The doctrine of 'equitable liens' * * * was introduced for the sole purpose of furnishing a ground for the specific remedies which equity confers, operating upon particular identified property, instead of the general pecuniary recoveries granted by courts of law."). To be sure, "[w]here property is subject to an equitable lien and the owner of the property disposes of it and acquires other property in exchange, he holds the property so acquired subject to the lien."[3] Restatement § 161 cmt. e, at 652-653; see *id.* §§ 202(b), 203, at 818, 828. Similarly, when the property in question is "mingled with other property in one indistinguishable mass, the lien can be enforced against the mingled mass." *Id.* § 161 cmt. e, at 653.

As particularly relevant here, however, where "the property subject to the equitable lien [or constructive trust] can no longer be traced, the equitable lien cannot be enforced." Restatement § 161 cmt. e, at 653; see, *e.g.*, *Freshwater* v. *Colonial Prod. Credit Ass'n*, 334 S.E.2d 142, 145 (S.C. Ct. App. 1985) (where party "dissipated" proceeds allegedly subject to an equitable lien by agreement, there was "nothing to which the equitable lien could attach"). That is because "[t]he equitable lien is destroyed by the dissipation of the fund." *Whiting* v. *Hudson Trust Co.*, 138 N.E. 33, 38

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[3] If petitioner had exchanged the identified funds for other identifiable property, respondent could enforce the lien against that property. In addition, if a third party had taken possession of the identified funds with notice of the lien, respondent could enforce the lien against that party. See 4 *Pomeroy* § 1235, at 696.

(N.Y. 1923) (citing *Schuyler* v. *Littlefield*, 232 U.S. 707 (1914)). Thus, "where a person wrongfully disposes of the property of another but the property cannot be traced into any product, the other has merely a personal claim against the wrongdoer and cannot enforce a constructive trust or lien upon any part of the wrongdoer's property."[4] Restatement § 215(1), at 866; see *Great-West*, 534 U.S. at 213-214 (quoting Restatement § 215 cmt. a, at 867).

b. Similarly, a constructive trust may not be enforced against a constructive trustee, such as a plan participant or beneficiary in an overpayment case, who dissipated the assets at issue.[5] See, *e.g.*, 4 *Pomeroy* § 1058c, at 148-149 (property is subject to constructive trust only if it can be identified); Restatement § 160 cmt. g, at 648 (constructive trust cannot be enforced when "property is transferred to a bona fide purchaser" without notice); *id.* § 172, at 691-692. That was so because a "constructive trust, unlike an express trust, is not a fiduciary relation." *Id.* § 160 cmt.

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[4] It therefore does not matter that "the lien * * * attached" when the funds came into petitioner's possession. Br. in Opp. 18. At equity, when the defendant disposed of property to which a lien had attached, the lien could no longer be enforced.

[5] Because any trust in this case was constructive, not express, make-whole relief against petitioner personally in the form of an equitable surcharge is unavailable. This Court recently held that ERISA Section 502(a)(3) allows a suit *by* a plan participant for an equitable surcharge against a plan fiduciary, "whom ERISA typically treats as a trustee." *CIGNA*, 131 S. Ct. at 1879. ERISA fiduciaries are expressly charged under the statute with the highest trust-law duties of loyalty and care. See *Mertens*, 508 U.S. at 253, 262-263. But nothing in the statutory scheme itself imposes similar fiduciary obligations on plan participants and beneficiaries.

a, at 641; see generally 5 Austin Wakeman Scott, *The Law of Trusts* § 462.1, at 3415 (3d ed. 1967).

2. Respondent is incorrect in arguing that monetary compensation for dissipated property was traditionally treated as equitable relief

Respondent contends (Br. in Opp. 18-20) that courts of equity awarded monetary relief as a substitute for enforcing an equitable lien or constructive trust when the entire property subject to the lien was no longer in the defendant's possession. In particular, respondent argues that it is entitled either to a deficiency judgment or to damages. In equity, however, both types of relief were considered legal in nature, and equity courts awarded them purely as a matter of ancillary jurisdiction.

a. Deficiency judgments

At equity, an equitable lien was traditionally enforced through foreclosure of the identified property in the defendant's possession. 1 Dan B. Dobbs, *Law of Remedies* § 1.4, at 19 (2d ed. 1993) (*Dobbs*). When the foreclosure sale of the property did not result in proceeds sufficient to satisfy the defendant's debt to the plaintiff, equity courts could award a money judgment, often called a deficiency judgment, for the amount of the shortfall. 1 *Pomeroy* § 240, at 450. That remedy was legal in nature, however, and equity courts had authority to award it only as part of their ancillary jurisdiction to award complete relief between the parties.

In cases in which "a court of equity ha[d] obtained jurisdiction over some portion or feature of a controversy," it generally had ancillary jurisdiction to "proceed to decide the whole issues, and to award com-

plete relief, although the rights of the parties are strictly legal, and the final remedy granted is of the kind which might be conferred by a court of law." 1 *Pomeroy* § 231, at 410; see *id.* § 181, at 257 (equity court may "grant legal remedies which would otherwise be beyond the scope of its authority"). Such relief was sometimes called "clean up" relief, *Dobbs* § 2.7, at 180, and the rationale for permitting courts to award it was to promote "economy of litigation." *ibid.*; 1 *Pomeroy* § 242, at 456.

According to Pomeroy, one example of a supplemental legal remedy that could be awarded by an equity court was a "money judgment[]" in the form of a deficiency judgment. 1 *Pomeroy* § 240, at 450. Thus, when equity courts awarded monetary relief because the sale of the property securing an equitable lien did not fully satisfy the plaintiff's interest, they understood that remedy to be legal, not equitable, in nature. See, *e.g.*, *Jefferson Standard Life Ins. Co.* v. *Buckman*, 82 F.2d 125, 126 (5th Cir. 1936) ("the ascertainment of the amount of a debt and giving judgment for it is the function of a court of law, so that a deficiency decree is ordinarily an encroachment upon the jurisdiction of the law courts").

Indeed, deficiency judgments were initially thought to be a form of legal relief that fell outside of equity jurisdiction altogether. Nineteenth-century chancery courts in the United States and England viewed deficiency judgments as an exception to the rule that equity courts could award legal as well as equitable relief, and they held that deficiency judgments "could only be obtained by an action at law." 1 *Pomeroy* § 240, at 451; see *Noonan* v. *Lee*, 67 U.S. 499, 509 (1863). Eventually, through "statutory provisions

authorizing a personal judgment or through judicial decisions upholding the right," equity courts obtained the authority to "render a deficiency judgment" in order to "relieve parties from the expense and vexation of two suits, one equitable and the other legal, where the whole controversy could be adjusted in the suit." 1 *Pomeroy* § 240, at 451.

Federal Rule of Equity 10, on which respondent relies (Br. in Opp. 19), was one such measure. That rule provided that "[i]n suits for the foreclosure of mortgages, or the enforcement of other liens, a decree may be rendered for any balance that may be found due to the plaintiff over and above the proceeds of the sale." Fed. R. Equity 10 (1912). As this Court explained, Rule 10 and its predecessor, Rule 92, "enlarg[ed] the Chancellor's jurisdiction, in order to completely dispose of the cause before him." *Hartford Accident & Indem. Co.* v. *Southern Pac. Co.*, 273 U.S. 207, 217-218 (1927). It was thus an application of the general equitable principle that a court may "award complete relief, even where the rights of parties are strictly legal and the final remedy granted is of the kind which might be conferred by a court of law." *Ibid.* After the Rule's adoption, courts continued to characterize the deficiency judgment as legal in nature.[6] See, *e.g.*, *Jefferson Standard*, 82 F.2d at 126 (Rule 10 permits a

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[6] The decisions on which respondent relies (Br. in Opp. 19) do not suggest that a deficiency judgment under Rule 10 was considered equitable in nature. See *Continental-Equitable Title & Trust Co.* v. *National Props. Co.*, 273 F. 967, 969 (D. Del. 1921) (explaining that Rule 10 provided ancillary jurisdiction, and approvingly citing *Frank* v. *Davis*, 31 N.E. 1100 (N.Y. 1892), which stated that deficiency judgments were legal relief); *Phelps* v. *Loyhed*, 19 F. Cas. 461 (C.C.D. Minn. 1871) (No. 11,077) (stating that court had power to grant deficiency decree).

deficiency decree notwithstanding its legal nature.); *Northwestern Mut. Life Ins. Co.* v. *Keith*, 77 F. 374, 375 (8th Cir. 1896) (same). Contrary to respondent's contention, then, Rule 10 does not suggest that a deficiency judgment was equitable in nature; rather, it demonstrates the opposite.

b. Damages for destruction of a lien

Respondent also suggests that equity courts could award "compensation" when a defendant dissipated or destroyed property to which a lien had attached. See Br. in Opp. 19 (citing *Otis* v. *Otis*, 45 N.E. 737 (Mass. 1897)). But that remedy was also legal in nature.

In equity, some courts stated that "[i]f the owner of property subject to an equitable lien disposes of it, in hostility to the lien, so that the lien is destroyed," the lienor may seek "damages for the destruction of the lien." *Jones* § 95, at 65; see *Hale* v. *Omaha Nat'l Bank*, 64 N.Y. 550, 555 (1876). A damages award for destruction of a lien was, like a deficiency judgment, legal relief that a court in equity could award as a matter of its ancillary jurisdiction. See *Jones* §§ 1034, 1036, at 678-679 (remedy was action for trover, a legal remedy, to obtain "compensation" for loss); see also *Hovey* v. *Elliott*, 23 N.E. 475, 478 (N.Y. 1890) ("action at law" for destruction of lien); *J.G. White Eng'g Corp.* v. *People's State Bank*, 87 So. 753, 756 (Fla. 1921) (when property held subject to a mortgage is destroyed, "such mortgagee's remedy would be at law, in an action on case, for such damages as he may sustain"); *Shultz* v. *Shively*, 143 P. 1115, 1119 (Or. 1914) (same).

3. Respondent may not obtain legal relief under Section 502(a)(3) simply because equity courts had authority to award that relief

The monetary relief that respondent seeks here is precisely the sort of relief that this Court has held is unavailable under Section 502(a)(3). In *Mertens*, the Court expressly rejected the argument that legal relief that an equity court could award pursuant to its ancillary jurisdiction constituted "equitable relief" for purposes of Section 502(a)(3). 508 U.S. at 256 (citing Pomeroy's discussion of "clean up" relief, 1 *Pomeroy* § 181, at 257); see pp. 8-9, *supra*. And in *Great-West*, all nine Members of the Court reaffirmed that compensatory damages against a non-fiduciary awarded by equity courts as ancillary "clean up" relief constituted legal relief that should not be available under Section 502(a)(3). See 534 U.S. at 210; see *id.* at 234 (Ginsburg, J., dissenting) (under the dissenting Justices' construction of Section 502(a)(3), compensatory and punitive "clean up" relief would be unavailable); cf. *CIGNA*, 131 S. Ct. at 1880 (recognizing that "equitable relief" encompasses compensation from a *fiduciary* for losses).

Permitting plan fiduciaries to seek a deficiency judgment when the beneficiary no longer possesses the funds in question would render Section 502(a)(3)'s limitation on available relief "superfluous." *Mertens*, 508 U.S. at 258. If a plan could simply seek a deficiency judgment whenever there is no longer an identified fund in the beneficiary's possession, the equitable-lien action recognized in *Great-West* would become an empty formality. Simply by invoking an equitable lien in its pleadings, the fiduciary would be able to obtain

compensatory relief out of the beneficiary's general assets.

C. Permitting A Fiduciary To Enforce An Equitable Lien Only Against Identified Third-Party Recovery Funds In The Defendant's Possession Is Consistent With ERISA's Design

Under *Great-West* and the relevant equitable principles, a fiduciary may obtain reimbursement from a beneficiary by enforcing an equitable lien on an identified fund (or commingled funds or identifiable property for which the fund was exchanged) in the beneficiary's possession, but it may not seek to impose personal liability on a beneficiary who has spent the funds in question. 534 U.S. at 220-221. That result follows from Congress's decision to limit the available relief to "equitable relief." 29 U.S.C. 1132(a)(3).

It is true that there will be some cases in which the fiduciary will be unable to recover the reimbursement to which it is entitled under the plan. That consequence can prevent full effectuation of ERISA's purpose to protect and enforce plan terms. See *US Airways*, 133 S. Ct. at 1548. But the potential for beneficiaries to dissipate third-party recoveries has been clear since *Great-West*. Congress has not acted to override this Court's construction of Section 502(a)(3) in reimbursement cases. Fiduciaries, moreover, have adopted several practices that should enable them to protect their rights to reimbursement in most cases.

1. Great-West indicates that the present-possession requirement is not inconsistent with ERISA

Respondent contends that it would be "truly inequitable" to hold that plan fiduciaries may not obtain reimbursement when the beneficiary no longer pos-

sesses the funds in question. Br. in Opp. 20. This Court rejected that same argument in *Great-West*, where the equities between the parties were materially similar to those at issue here. 534 U.S. at 220. There, the fiduciary had attempted to protect its interest in reimbursement by notifying the beneficiary of that interest, attempting to negotiate a settlement of its claim, and seeking an order restraining dissipation of the settlement fund. *Id.* at 207-208. Despite knowing of the fiduciary's claim, the beneficiary sought state-court approval of a settlement contemplating that the money would be disbursed without reserving the amount in dispute. Ct. Appointed Amicus Br. at 10, *Great-West*, *supra* (No. 99-1786); *Great-West*, 534 U.S. at 208, 214. Notwithstanding the fiduciary's contention that the beneficiary had knowingly breached her obligations under the plan by refusing to reimburse the plan, Pet. Br. at 24, *Great-West*, *supra* (No. 99-1786), the Court held that the fact that the beneficiary did not possess the funds in question was dispositive. 534 U.S. at 214-215, 220.

Great-West also rejected the fiduciary's argument that disallowing reimbursement when the beneficiary did not possess the funds in question was inconsistent with ERISA's "basic purpose" of enforcing plan terms. 534 U.S. at 220-221 (citation omitted). The Court explained that while Congress provided beneficiaries with a broad right to file suit "to enforce [their] rights under the terms of the plan," 29 U.S.C. 1132(a)(1)(B), Congress "did not extend the same authorization to fiduciaries." *Great-West*, 534 U.S. at 221. Instead, Congress limited the situations in which fiduciaries may use Section 502(a)(3) to enforce plan terms to cases in which they seek "equitable relief."

Since *Great-West*, moreover, the possibility that fiduciaries may be unable to obtain reimbursement of already-disbursed funds has been clear.[7] Had Congress disagreed with the Court's construction of "equitable relief" in *Mertens* and *Great-West*, or the logical implication that fiduciaries may be left without a reimbursement remedy when the beneficiary does not possess the third-party recovery fund (or substitute assets) at the time of suit, it could have amended Section 502(a)(3). See *Kimble* v. *Marvel Entm't, LLC*, No. 13-720, 2015 WL 2473380, at *7 (June 22, 2015); see also *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring) (suggesting that Congress should overturn this Court's construction of Section 502(a)(3)).

Notably, Congress has overturned the Court's construction of "equitable relief" in the context of certain claims by participants and beneficiaries. In 1994, Congress amended Section 502(a)(3) to provide that beneficiaries and the Secretary of Labor may sue for "appropriate relief" in connection with a fiduciary's conduct in terminating certain pension plans. See Pension Annuitants Protection Act of 1994, Pub. L. No. 103-401, 108 Stat. 4172, 4172; 139 Cong. Rec.

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[7] See, *e.g.*, Bart A. Karwath, *ERISA Health Plan Reimbursement Claims After* Great-West Life & Annuity Insurance Co. v. Knudson, 47 Res Gestae 36, 39 (Apr. 2004) ("The Supreme Court's decision in *Great-West* has made it more difficult for ERISA plans to enforce their reimbursement provisions."); see also Philip R. O'Brien & Sarah A. Huck, *Preservation of Plan Assets Through Subrogation and Reimbursement Rights*—Part 2, 44 Benefits & Comp. Digest 24, 26 (Feb. 2008) ("One of the major problems created by [*Great-West*] is that its requirement that the settlement funds be identifiable and not paid out provides an incentive for plan participants to try to 'hide' and 'dissipate' settlement funds.").

17,876 (1993) (statement of Sen. Metzenbaum) (bill was intended to overturn *Mertens*' construction of "equitable relief" as applied to certain pension claims). After *Great-West*, Congress considered amending Section 502(a)(3), but did not ultimately do so. See, *e.g.*, Employee Pension Freedom Act of 2002, H.R. 3657, 107th Cong. § 403(c) (2002).

2. Plan fiduciaries have available methods of protecting their reimbursement interests

Since *Great-West*, fiduciaries have used several methods to protect their right to reimbursement and preserve their ability to enforce an equitable lien.

As an initial matter, fiduciaries have taken a number of steps to ensure that they receive adequate notice when their reimbursement rights are implicated. A fiduciary will generally learn that it may have reimbursement rights when the participant requests medical or other benefits after an incident for which a third party may be liable. Plans often require the participant to pursue a third-party recovery, and then require the participant to provide notice of any tort action or settlement. See Johnny Parker, *The Common Fund Doctrine: Coming of Age in the Law of Insurance Subrogation*, 31 Ind. L. Rev. 313, 331 (1998). Supplementing notice requirements, plans monitor the progress of participant suits against third-party sources. See Philip R. O'Brien & Sarah A. Huck, *Preservation of Plan Assets Through Subrogation and Reimbursement Rights*—Part 2, 44 Benefits & Comp. Digest 24, 26 (Feb. 2008) (*Preservation*) ("[I]t is vital that plans * * * monitor continuously the underlying actions to ensure that funds are not spent before the plans are reimbursed.").

In some cases, fiduciaries will not need to rely on a subsequent reimbursement action under Section 502(a)(3) to recoup their costs. Plan terms often give the fiduciary the right to file suit directly against any third-party tortfeasors as a subrogee of the beneficiary's claims, and plans may exercise that option when subrogation is permitted under state law. See, *e.g.*, *Atteberry* v. *Memorial-Hermann Healthcare Sys.*, 405 F.3d 344, 348-349 (5th Cir.), cert. denied, 546 U.S. 936 (2005); *Dayton Hudson Dep't Store Co.* v. *Auto-Owners Ins. Co.*, 953 F. Supp. 177, 179 (W.D. Mich. 1995). Alternatively, the fiduciary may be able to intervene in the participant's tort suit in order to protect its interest in any recovery. See, *e.g.*, *Maricco* v. *Meco Corp.*, 316 F. Supp. 2d 524 (E.D. Mich. 2004); *Crump* v. *Wal-Mart Grp. Health Plan*, 925 F. Supp. 1214, 1216 (W.D. Ky. 1996).

Even when a fiduciary does not participate directly in an action against a third party, it can protect its reimbursement rights by expeditiously asserting them. See *Preservation* 26; C. Mark Humbert, *The Supreme Court Revisits Third-Party Reimbursement Claims Under ERISA:* Sereboff v. Mid-Atlantic Medical Services, Inc., 18 Health Law. 1, 4 (Aug. 2006) (fiduciaries should "act *quickly* to enforce an equitable lien by assignment or agreement, * * * before the recovery is dissipated"). Since *Great-West*, plans seeking reimbursement have routinely been able to obtain TROs requiring the disputed portion of the recovery to be set aside pending resolution of the reimbursement claim. See, *e.g.*, *Sereboff*, 547 U.S. at 360 (fund was segregated after fiduciary sought TRO); *Crawford & Co. Med. Benefit Trust* v. *Repp*, No. 11C50155, 2011 WL 2531844 (N.D. Ill. June 24, 2011);

Mank v. *Green*, 297 F. Supp. 2d 297 (D. Me. 2003); see also *Diamond Crystal Brands, Inc.* v. *Wallace*, 531 F. Supp. 2d 1366 (N.D. Ga 2008). In addition, when settlement funds are disbursed to the participant's attorney, ethical rules may require the attorney to set aside funds in which the fiduciary has asserted an interest. See, *e.g.*, ABA, *Model Rules of Professional Conduct* 1.15(e) (2013).

D. A Remand Is Necessary To Determine The Extent To Which Petitioner Possesses Funds Or Property Against Which Respondent May Enforce Its Equitable Lien

Respondent may enforce its equitable lien only against specific, identified funds (or commingled funds or identifiable property for which the funds were exchanged) that remain in petitioner's possession. In this case, such funds may no longer exist. Pet. App. 35 n.2; Pet. Br. 9.

Respondent does not appear to have availed itself of any of the numerous ways in which fiduciaries may protect their reimbursement rights. Respondent does not assert that it attempted to participate in or monitor petitioner's action against potentially liable third parties. See Compl. ¶¶ 14-15 (alleging on "information and belief" that petitioner had filed suit and received a settlement). Although the parties negotiated over respondent's reimbursement claim for several months, respondent did not seek a TRO during that time, even when petitioner's attorney stated that he intended to disburse funds after 14 days. Indeed, respondent waited to file this suit until approximately six months later. See p. 2, *supra*. In all, over a year passed between the start of negotiations and respondent's initiation of this suit.

When the district court issued its decision, it was unclear whether petitioner still possessed any of the funds at issue. See note 2, *supra*. The district court did not resolve the parties' dispute about that question. In addition, circumstances may have changed in the intervening period. The case should be remanded to permit the lower courts to determine the extent to which respondent may enforce its equitable lien against funds or property in petitioner's possession.

II. IF THE COURT CONCLUDES THAT A DEFICIENCY JUDGMENT OR LIEN-DESTRUCTION DAMAGES CONSTITUTES "EQUITABLE RELIEF," THE COURT SHOULD REMAND TO PERMIT THE LOWER COURTS TO DETERMINE WHETHER RESPONDENT HAS ESTABLISHED THE ELEMENTS OF THOSE CLAIMS

Even if this Court were to conclude that the monetary remedies respondent proposes are "equitable relief" under Section 502(a)(3), respondent would not be entitled to relief unless it can satisfy the prerequisites for receiving a deficiency judgment or damages. Cf. *CIGNA*, 131 S. Ct. at 1881 (beneficiary seeking equitable remedy of surcharge must satisfy the requirements of that cause of action). Although respondent argued below that it was entitled to reimbursement in the form of an equitable lien, it did not also assert that the court should award a deficiency judgment or damages. See J.A. 37-40. A remand would therefore be necessary to permit the lower courts to determine whether respondent is entitled to any monetary relief under either theory.

A. Because a deficiency judgment is designed to supplement the proceeds of a foreclosure sale, the remedy presupposes that the defendant possessed

some property subject to the plaintiff's lien, and the court was able to order a sale of that property. Courts therefore did not award a deficiency judgment when they were unable to order a foreclosure sale of the underlying property subject to the lien. See 1 *Pomeroy* § 240, at 451-452 ("[T]here can be no deficiency judgment in a foreclosure proceeding where the principal cause of action fails."); *City Bank* v. *Plank*, 124 N.W. 1000, 1003 (Wis. 1910) ("The order for deficiency judgment is so dependent on, and merely ancillary to, the foreclosure and sale that it would be absurd left standing alone.").

As a result, an ERISA fiduciary seeking a deficiency judgment would have to demonstrate that the beneficiary retains a portion of the recovery, such that the fiduciary's equitable lien is enforceable against that portion. Only in that circumstance could the fiduciary seek a deficiency judgment for the remainder of reimbursement amount. On remand, respondent would need to demonstrate that petitioner still possesses a portion of his recovery.

B. An action for damages for dissipating property subject to a lien required the plaintiff to demonstrate that the defendant had acted in bad faith, with knowledge of the plaintiff's rights in the lien and the intent to defeat those rights. See *Hovey*, 23 N.E. at 478 ("action at law" "would * * * lie" in event of sale with "intent to defraud or injure the plaintiffs in their lien, or with any purpose to defeat it"); see also *George Adams & Frederick Co.* v. *South Omaha Nat'l Bank*, 123 F. 641, 645 (8th Cir. 1903) (claim based on defendant's "wrongful[]" dissipation of property subject to a lien); *Yates* v. *Joyce*, 11 Johns. 136 (N.Y. Sup. Ct. 1814); *Jones* § 95, at 65.

Respondent would therefore have to demonstrate that petitioner spent the proceeds of his suit with knowledge of respondent's claim and the intent to deprive respondent of its right to reimbursement. Cf. *Jones* § 1036, at 679; 90 C.J.S. *Trover and Conversion* § 4 (2010) (stating intent requirement). While petitioner's knowledge of respondent's claim may be inferred from his attempt to settle the reimbursement dispute, there is currently no other evidence in the record concerning petitioner's intent in spending the portion of the recovery that he received.

CONCLUSION

The judgment of the court of appeals should be vacated and the case remanded for further proceedings.

Respectfully submitted.

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No. 14-723

IN THE
SUPREME COURT OF THE UNITED STATES

ROBERT MONTANILE,

Petitioner,

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Respondent.

On Writ of Certiorari
to the United States Court of Appeals
for the Eleventh Circuit

BRIEF AMICUS CURIAE OF AARP IN SUPPORT OF PETITIONER

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INTEREST OF AMICUS CURIAE[1]

AARP is a nonprofit, nonpartisan organization, with a membership that helps people over the age of 50 turn their goals and dreams into real possibilities, seeks to strengthen communities, and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities, and protection from financial abuse. In its efforts to foster the economic security of individuals as they age, AARP seeks to increase the availability, security, equity, and adequacy of public and private pension, health, disability and other employee benefits which countless members and older individuals receive or may be eligible to receive.

Participants in private, employer-sponsored employee benefit plans rely on the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et. seq.* (2012), to protect their rights under those plans. In particular, ERISA's protections, and plan participants' opportunities to enforce those protections, are of vital concern to

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[1] Pursuant to Supreme Court Rule 37, counsel of record received timely notice of the intent to file this brief and, on behalf of the parties, have consented to the filing of this brief. No counsel for a party authored this brief, in whole or in part; and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No party other than amicus or its counsel made a monetary contribution to its preparation or submission. Letters from the parties consenting to the filing of amicus briefs have been filed with the Clerk of the Court.

workers of all ages and to retirees, as the quality of their lives depends heavily on their eligibility for, and the amount of, retirement and welfare benefits.[2]

The resolution of this issue regarding reimbursement agreements in health plans will have an impact far beyond this case.[3] AARP notes that the Court's decision will impact disputes ranging from participant fraud on the plan, *Trustees of the AFTRA Health Fund v. Biondi*, 303 F.3d 765 (7th Cir. 2002) (keeping ex-spouse on health plan in violation of plan eligibility rules), to a plan's mistaken approval for health procedures that was relied upon to the

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[2] AARP has participated as amicus curiae in this Court to protect the rights of workers and their beneficiaries under ERISA. *See, e.g., CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011); *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

[3] For example, some health plans with reimbursement provisions refuse to pay any portion of attorneys' fees. Accordingly, part of the decision as to whether a participant should sue a third party tortfeasor is the amount, if any, of potential recovery. After payment of attorneys' fees and expenses, the participant's recovery could be less than the amount of medical benefits paid, and the participant could actually wind up owing the plan more than received from the tort case. *See, e.g., FMC Corp. v. Holliday*, 885 F.2d 79, 80 (3d Cir. 1989), *vacated and remanded*, 498 U.S. 52 (1990); *Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Shank*, 500 F.3d 834, 835 (8th Cir. 2007); *U.S. Airways, Inc. v. McCutchen*, 2010 U.S. Dist. LEXIS 89377, at *2-3 (W.D. Pa. 2010).

participant's detriment, *cf. Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869 (7th Cir. 2013) (after approval for gastric bypass surgery, participant underwent surgery and plan refused to pay), to disability benefit offsets. *E.g.*, *Renfro v. Funky Door Long Term Disability Plan*, 686 F.3d 1044 (9th Cir. 2012) (permitting insurer to double dip by applying Social Security offset to two disability policies). AARP's brief will focus on the issue of overpayment of pension benefits to participants where typically a plan mistakenly or negligently overpays the unknowing and unsuspecting participant.

The Court's decision will have a direct and vital bearing on the economic security of millions of workers, including members of AARP. In light of the significance of the issues presented by this case, AARP respectfully submits this brief to facilitate a full consideration by the Court of these issues.

SUMMARY OF ARGUMENT

Because many retirees rely on modest amounts of pension benefits and retirement savings as a supplement to Social Security, requests for repayment of overpayments of these benefits can be devastating to participants' retirement security. Although plans admit that it is usually their fault for the pension benefit overpayments, plans still demand repayment of these overpayments with interest at the plan's rate of investment return. Because many plans wait for inordinate periods of time to recoup these benefits, the amounts that participants owe can be hefty. Because equity permits individuals who are

not at fault to establish equitable defenses against restitutionary claims, the equitable defenses of laches and changed circumstances should be permitted where a plan asserts a claim for restitution under ERISA.

ARGUMENT

I. IN ORDER TO AFFORD BASIC LIVING EXPENSES, MANY RETIREES RELY ON MODEST AMOUNTS OF PENSION BENEFITS AND RETIREMENT SAVINGS TO SUPPLEMENT SOCIAL SECURITY.

Approximately one-third of people over the age of 65 have earned regular payments from pensions or retirement savings.[4] *See* Ke Bin Wu, *Sources of Income for Older Americans, 2012*, AARP Pub. Policy Inst. 1 (2013), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/econ_sec/2013/sources-of-income-for-older-americans-2012-fs-AARP-ppi-econ-sec.pdf. In 2012, the average amount of pension payments was $17,914 annually, with the median at $12,000. *Id.* at 3. Pensions and retirement savings supplement average monthly Social Security benefits. The average 2012 monthly Social Security benefit was $14,229 per year, with the median at

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[4] This income includes only regular payments such as an annuity or regular distribution from a traditional pension plan, 401(k) or Individual Retirement Account. Ke Bin Wu, *Sources of Income for Older Americans, 2012*, AARP Public Policy Inst. n.5 (2013), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/econ_sec/2013/sources-of-income-for-older-americans-2012-fs-AARP-ppi-econ-sec.pdf.

$13,972. *See id.*, at 1; *see also* Sudipto Banerjee, *Income Composition, Income Trends and Income Shortfalls of Older Households*, Emp. Benefit Research Inst. 1, 5 (2013), http://www.ebri.org/pdf/briefspdf/EBRI_IB_02-13.No383.IncmEld.pdf (showing the income composition of older households, including Social Security and pension benefits) (hereinafter "Banarjee, *Income Composition*").

Given these modest amounts, it is not surprising that most retirees spend their retirement income on living expenses including medical care. *See* Sudipto Banerjee, *Expenditure Patterns of Older Americans, 2001-2009*, Emp. Benefit Research Inst. (2012), http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=4992. For example, a 65-year old couple retiring in 2014 will need approximately $220,000 to cover medical expenses throughout their retirement. Fidelity Viewpoints, *Retiree Health Costs Hold Steady*, Fidelity Inv. (June 11, 2014), https://www.fidelity.com/viewpoints/retirement/retirees-medical-expenses. Although the amount of pension and retirement income that individuals receive is modest, individuals with such income are likely to be able to pay their expenses in their retirement. Banerjee, *Income Composition* at 14 (individuals with pension income were less likely to face income deficits than those without).

II. ALTHOUGH PLANS CONCEDE THAT PARTICIPANTS GENERALLY ARE NOT AT FAULT FOR OVERPAYMENTS, PENSION PLANS DEMAND PARTICIPANTS REPAY BENEFITS WITH INTEREST, DESPITE HAVING THE DISCRETION TO RECOUP THESE OVERPAYMENTS FROM OTHER SOURCES AND WITHOUT REGARD FOR ANY HARDSHIP.

A. Incorrect Pension Benefit Payments Are Not Uncommon Due To The Complexity Of Pension Calculations.

Pension benefit calculations require the use of many different pieces of information (such as birthdate, compensation and years of service) which can be incorrect or incomplete. *See, e.g.*, Dep't of Labor, *10 Common Causes Of Errors In Pension Calculation*, http://www.dol.gov/ebsa/Publications/10common.html (last visited July 8, 2015). Incorrect calculations lead to both over and underpayments. *See* Press Release, Pension Benefit Guar. Corp., *Pension Plans: Standard Termination Audit Findings* (June 16, 1997), http://www.pbgc.gov/news/press/releases/pr97-31a.html (finding benefit calculation errors are not uncommon).

Moreover, as more defined benefit pension plans provide participants the option to receive their pension benefits as a lump sum payment, *see* Sudipto Banerjee, *Annuity and Lump-Sum Decisions in Defined Benefit Plans: The Role of Plan Rules*, Emp. Benefit Research Inst. (2013), http://www.ebri.org/

pdf/briefspdf/EBRI_IB_01-13.No381.LSDs2.pdf, more miscalculations occur. First, the annuity amount must be calculated using birthdates, years of service and compensation along with the appropriate multiplier. Second, converting the annuity amount into a lump sum requires calculating the present value of the annuity amount using certain interest rates and mortality tables, while excluding certain features under the annuity calculation. *See* U.S. Gov't Accountability Office, GAO-15-74, *Private Pensions: Participants Need Better Information When Offered Lump Sums That Replace Their Lifetime Benefits* 14-18, 19-22, 60-71 (2015); Dep't of Labor, Office of Inspector Gen., *PWBA Needs to Improve Oversight of Cash Balance Plan Lump Sum Distributions* 11-17 (2002) (finding 22 % of plans underpaid participants in cash balance plans).

Given the complexity of these calculations, the supposed expertise of pension plans, and the lack of knowledge and sophistication of participants, it is unsurprising that individuals would be totally unaware that a mistake has been made in their benefits determination. Not only are participants unprepared for their retirement benefit to be significantly reduced, but they are ill-equipped to have to pay back a portion of already received funds. Most often, participants will have already budgeted and spent received benefits to finance basic living expenses and are unable to absorb such a costly change in financial circumstances. *See* Sudipto Banerjee, *Expenditure Patterns of Older Americans, 2001-2009*, Emp. Benefit Research Inst. (2012),

http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=4992.

B. Although Fiduciaries Must Attempt To Recoup Overpayments, They Are Not Limited To Obtaining Repayment From The Participant.

While plan fiduciaries are required to attempt to recoup overpayments, plan fiduciaries have discretion in deciding from whom to seek the money. All three government agencies charged with overseeing ERISA plans require a plan fiduciary to attempt to recoup overpayments made to participants, but recognizing the potential hardship to participants, allow fiduciaries to use their discretion to determine the best manner to obtain the repayments from sources other than the participants.

The Internal Revenue Service (IRS) focuses on the requirement that fiduciaries must operate the plan in accordance with the plan terms and, accordingly, must attempt to recover erroneous payments. *See, e.g.*, Rev. Proc. 2013-12, 2013-4 I.R.B. 313 (Jan. 22, 2013), §§ 5.01(1)-(2), 5.01(2)(b), 6.02(1). The IRS considers incorrectly paid pensions as operational defects that must be corrected; otherwise, the plan could lose its tax qualification. *See id.* at §§ 5.01(2), (3)(c). Where there are overpayments at issue for a defined benefit or defined contribution plan, the plan can recover from the administrator, the plan sponsor or the participant. *See id.* at § 6.02(5), as amended Rev. Proc. 2015-27, 2015-16 I.R.B. 914 (Apr. 20, 2015), §§ 6.06(3),

6.06(4)(f); Rev. Proc. 2013-12, Appx. B, § 2.04(1)(a)(i). The plan must take reasonable steps not only to recover the overpayment itself, but "interest" at the rate of the plan's investment return. *See* Rev. Proc. 2013-12, Appx. B, § 2.04(1)(a)(i). However, if the amount is small, the participant cannot be found, or the collection costs would be burdensome, the IRS permits fiduciaries to forgo collection efforts. *See* Rev. Proc. 2013-12, § 6.02(5), as amended Rev. Proc. 2015-27, §§ 6.06(3), 6.06(4)(f); Rev. Proc. 2013-12, Appx. B, § 2.04(1)(a)(i).

In contrast, the emphasis for the Department of Labor is on the fiduciaries' prudence in discharging their duties. Relying on ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1), the Department has stated that a fiduciary has an obligation "to recover erroneous payments made from a plan." Dep't of Labor, PWBA, Advisory Opinion 77-08, 2 (Apr. 4, 1977), 1977 ERISA LEXIS 56. Depending on the circumstances, the fiduciaries may have numerous options to recover the erroneous payments including repayment from a third party administrator or the participant. *Id.* However, the fiduciary also can determine that recouping the benefits from the participant might cause too great a hardship on the participant or the cost might be too high for the amount recovered. *Id.*; *accord*, Dep't of Labor, PWBA, Advisory Opinion 77-07 (Apr. 4, 1977), 1977 ERISA LEXIS 55 (opining that offsetting of benefits to recoup a related plan's overpayment would be a breach of fiduciary duty). This discretion allows plan fiduciaries to recoup overpayments from other sources and can reduce the burden on unsophisticated plan participants.

Finally, the Pension Benefit Guaranty Corporation will recoup overpayments made to a participant by reducing future benefits, 29 C.F.R. §§ 4022.81(a), 4022.82(a), but the reduction is capped, 29 C.F.R. § 4022.82(a)(2), to prevent hardship to the participant.

Although a plan has options other than repayment directly from the participant, even where the overpayment was admittedly the plan's fault, many plans only attempt to obtain recovery from the participant.

C. Recoupment Of Overpayments Can Be Devastating To The Retirement Security Of Individuals.

A "secure, comfortable retirement is every worker's dream." Social Security Admin., *Retirement Planner: Plan For Your Retirement*, http://www.ssa.gov/planners/retire/ (last visited July 8, 2015). That dream is achievable "when you plan your finances." *Id.*; *see generally* Dept. of Labor, *Top 10 Ways to Beat the Clock and Prepare for Retirement*, http://www.dol.gov/ebsa/publications/10_ways_to_prepare.html (last visited July 8, 2015) ("The key to a secure retirement is to plan ahead."). Anticipated pension and annuity payments are critical parts of the retirement calculus. *See* Constantijn Panis, et al., *The Effects of Changing Social Security Administration's Early Retirement Age and the Normal Retirement Age*, Social Security Admin., 53 (2002), http://www.ssa.gov/policy/docs/contractreports/agereport.pdf (Prepared for SSA by RAND).

Yet these well-laid plans are capsized when there is a significant reduction in pension payments or a requirement to return a lump sum amount to the pension plan because the plan overpaid benefits. There has been a recent uptick in media stories about individuals who are informed that their retirement benefits were incorrectly calculated and they were overpaid. *See* Eleanor Laise, *Surprise, Retirees! Return the Benefits*, Kiplinger (July 2012), http://www.kiplinger.com/article/retirement/T037-C000-S001-surprise-retirees-return-the-benefits.html (hereinafter "Laise, *Surprise, Retirees!*"). Whatever caused these overpayments, the retirees usually have no idea that they have been overpaid and usually are shocked when there is a demand for a lump sum repayment or a slash in future benefits. *Id.*

The poster child for these types of stories is the Sheet Metal Workers Local 73 Pension Plan. In 2010, as a result of an audit,[5] the Pension Plan discovered it had been overpaying participants for up to thirty years. Even after discovering the overpayments, the plan did not demand repayment – with interest – for well over three years. One 79-year old pensioner was allegedly overpaid for seventeen years in the amount of $105,507, which included $44,525 in interest. *See*

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[5] AARP notes that pension plans are required to be audited annually. These audits include testing of the accuracy of benefit calculations. Dep't of Labor, Emp. Benefits Sec. Admin., Office of the Chief Accountant, *Assessing the Quality of Employee Benefit Plan Audits* 2, 17, 22, 42-43 (2015), http://www.dol.gov/ebsa/pdf/2014AuditReport.pdf. This certainly raises the issue of laches when plans wait inordinate periods of time to demand repayment.

Michelle Smith, *Pension Funds Aggressively Recouping Overpayments*, NewsMax Fin. (Oct. 25, 2013, 8:24 AM), http://www.newsmax.com/Finance/Personal-Finance/pension-sheet-metal-overpaid/2013/10/25/id/533046/ (hereinafter "Smith, *Pension Funds*); *see also* Pam Zekman, *2 Investigators: Pension Fund Demands Overpayments Back, With Interest*, CBS Chicago (Sept. 27, 2013, 10:03 PM), http://chicago.cbslocal.com/2013/09/27/2-investigators-pension-fund-demands-overpayments-back-with-interest/. Even small amounts of overpayments over a long period, combined with interest, makes a lump sum repayment devastating and impossible. Forcing retirees to pay back such a large amount threatens their financial security and their ability to afford basic expenses such as food, clothing, and shelter.

The Sheet Metal Pension Plan is just one of many pension plans that have been aggressively attempting to recoup overpayments. *See* Alyssa Rosenberg, *System error cuts DAK Americas employee's retirement package by $120,000*, WWAYTV3.com (Dec. 13, 2013, 2:00 AM), http://www.wwaytv3.com/2013/12/12/system-error-cuts-dak-americas-employees-retirement-package-120000/ (informing retirees that they must repay money due to employer's admitted, but unexplained, calculation error); Smith, *Pension Funds* (claiming an overpayment of $45,000 over five years, American Water Works Plan lowered pension to the correct amount; after deductions of $300 for repayment and health care premium, pensioner now receives less than $25 per month); Len Boselovic, *Accounting Mistakes Can Squeeze Pension Benefits*, Pittsburgh

Post-Gazette (July 6, 2014, 12:00 AM), http://www.post-gazette.com/business/2014/07/06/Accounting-mistakes-can-squeeze-pension-benefits/stories/201407060084 (after an audit, plan informed widow that she had been overpaid $19 per month for sixteen years; plan lowered pension benefit by $52 per month for the rest of her life, even if overpayment is repaid).

These demands for recoupment can turn the retiree's life upside down. Plans first adjust the monthly benefit to the correct amount. Plans then calculate the repayment amount with interest at the rate of the plan's investment return. The plans recoup the calculated amounts by demanding a lump sum payment, cutting future benefits, or both. A plan demands a lump sum payment when the plan concludes that the retiree will most likely die before making total repayment through benefit offsets, placing an even greater immediate financial stress on the individual. *See* Laise, *Surprise, Retirees!*.; Pam Zekman, *2 Investigators: Pension Fund Demands Overpayments Back, With Interest*, CBS Chicago (Sept. 27, 2013, 10:03 PM), http://chicago.cbslocal.com/2013/09/27/2-investigators-pension-fund-demands-overpayments-back-with-interest/; Adam Benson, *Former Triangle Wire Workers Fight to Retain Pensions*, The Bulletin (Dec. 23, 2014, 10:21 PM),http://www.norwichbulletin.com/article/20141223/NEWS/141229753 (70-year old retiree informed pension benefit had been incorrectly calculated for 22 years so benefit was lowered; 3 years later, plan not

only zeroed out the benefit to recoup the overpayment, but demanded an additional $900).

The impact on these retirees can be drastic. Not only are their benefits reduced, but they also may be asked to pay back sizable sums without any way to finance the unexpected costs with a supplemental source of income.[6] Many retirees do not even have the option of returning to work to make up the difference in their income due to the loss of benefits because they have been out of the workforce for so long. *Cf.* Gary Koenig, Lori Trawinski, & Sara Rix, *The Long Road Back: Struggling to Find Work After Unemployment*, AARP Pub. Policy Inst. (2015), http://www.aarp.org/content/dam/aarp/ppi/2015-03/The-Long-Road-Back_INSIGHT.pdf. (detailing difficulties of workers over age 55 finding employment). Moreover, the retirees may not have any significant assets to help with the financing of the repayment. *See* Ke Bin Wu, *Sources of Income for Older Americans, 2012*, AARP Pub. Policy Inst. 3-5 (2013), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/econ_sec/2013/sources-of-income-for-older-americans-2012-fs-AARP-ppi-ec

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[6] Indeed, participants may be outside the permitted period to amend their tax returns to adjust for the repaid income. Individuals generally have three years in which to amend their tax returns to obtain a credit or refund. *See* Dep't of Treasury, Internal Revenue Service, *Instructions for Form 1040X, Amended U.S. Individual Income Tax Return* 2 (Rev. Dec. 2014), http://www.irs.gov/pub/irs-pdf/i1040x.pdf. We note that changes in individuals' income due to overpayments may also affect those individuals who were ordered to pay child support or alimony.

on-sec.pdf. Because retirees cannot absorb the large financial burden of repayment of the miscalculated funds along with their reduced payment, they may be forced to rely on government assistance to afford basic necessities such as food or electricity. *See* National Council of Aging, *BenefitsCheckUp*, https://www.benefitscheckup.org/find-help (last visited July 8, 2015) (explaining the various state, federal, and private benefits programs available to seniors to assist with payment for prescriptions, health care, food, utilities, and taxes, many based solely on amount of income).

Given the long timeframe before a demand for repayment of the miscalculated payments (with interest) is made, it is inequitable to force retirees living on fixed incomes to pay for the plan's mistake and negligence where the retiree is clearly not at fault. Indeed, after these long time periods, the retiree has usually experienced a significant change of circumstances, having spent the money, which they well may not have spent if they had not received it.

III. EQUITY PERMITS INDIVIDUALS WHO ARE NOT AT FAULT TO ESTABLISH EQUITABLE DEFENSES AGAINST RESTITUTIONARY CLAIMS AND SUCH DEFENSES SHOULD BE PERMITTED UNDER ERISA.

This Court has made clear that equitable relief under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), means relief that was typically available in equity.

See Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 210 (2002); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993). Consequently, equitable restitution may be available to plans to recover overpayments, but such claims are also subject to equitable defenses such as changed circumstances and laches.

Restitution is an equitable remedy based on the fundamental principles of fairness. *See Restatements (Third) on Restitution and Unjust Enrichment* § 65 (Am. Law Inst. 2011). The law of restitution has long recognized that if an unknowing recipient of an overpayment has changed his or her position, restitution may not be required if to do so would be inequitable to the recipient. *See id.* As a defense to a claim for restitution, changes of position due to expenditure and consumption are fact dependent. *Id.* at § 65(c). Although spending on living expenses is frequently not considered a change of position, it is not quite so simple. If "the expenditure is one that would not have been made, but for the [over]payment," *id.*, most courts find that the recipient has suffered a change in circumstances and restitution would not be granted. *Id.*; *accord, Avon County Council v. Howlett*, [1983] 1 WLR 605 (Eng.) (change of circumstances permitted as defense where individual would not have purchased everyday items if he had not received said money); *RBC Dominion Securities Inc. v. Dawson*, [1994] 111 DLR (4th) 230 (Nfld.) (change of circumstances permitted as defense where individual used money for clothing and furnishings she would not have bought but for receipt of the money).

Moreover, if substantial time has elapsed between the overpayment and the claim for restitution or recoupment, many courts may conclude that requiring repayment after such a long time would be inequitable to the recipient. *Restatements (Third) on Restitution and Unjust Enrichment* §§ 65, 70 (Am. Law Inst. 2011).

Finally, if restitution would result in manifest hardship, some courts will conclude that the expenditure of the funds on living expenses would make it inequitable to require restitution. *Id.* at Reporter's Notes, c., illus. 12; *accord*, Dan B. Dobbs, 2 *Law of Remedies: Damages-Equity-Restitution* § 11.8 at 769-70 (2d ed. 1993) (noting restitution denied where overpayment used for medical bills).

Here, in the ERISA context, participants who are not at fault should not be required to repay overpayments made long ago, whether it is in a lump sum or through a reduction in future payments. At the very least, participants should be able to defend against the plan's restitutionary claims with appropriate equitable defenses including changed circumstances and laches.

CONCLUSION

For the foregoing reasons, the judgment of the Eleventh Circuit should be reversed and the case remanded for further proceedings.

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No. 14-723

IN THE

Supreme Court of the United States

ROBERT MONTANILE,

Petitioner,

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY BENEFIT PLAN,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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IDENTITY AND INTEREST OF AMICUS

The American Association for Justice respectfully submits this brief as amicus curiae to address the single issue in this case, whether an ERISA plan fiduciary can hold a plan participant or beneficiary personally liable to reimburse the plan for benefits after the participant or beneficiary dissipated settlement funds owed to the plan under a reimbursement provision.[1]

The American Association for Justice is a voluntary bar association of trial lawyers who primarily represent individual plaintiffs in personal injury cases and other civil actions. Although the Court's resolution of this question may affect reimbursement of pension and disability benefits, the American Association for Justice is primarily concerned with its impact on injured victims who are targeted by recoupment companies demanding repayment of medical benefits. American Association for Justice members frequently represent those injured victims and must deal with the practical problems posed by aggressive enforcement of obscure, opaque, and unfair reimbursement provisions.

The decision below, and the decisions of other federal circuit courts that permit ERISA plan fiduciaries to satisfy their reimbursement claims out of the general assets of their beneficiaries, does not

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[1] Blanket letters of consent to the filing of amicus briefs have been filed with the Court by Petitioner and Respondent. The undersigned counsel for *amicus curiae* affirms, pursuant to Supreme Court Rule 37.6, that no counsel for a party authored this brief in whole or in part and no person or entity other than *amicus curiae*, its members, and its counsel contributed monetarily to the preparation or submission of this brief.

grant "appropriate equitable relief," is not necessary to protect the rights of ERISA plans, will not benefit ERISA plans and plan participants generally, and will undermine ERISA's purpose of fostering employee benefit plans.

The American Association for Justice is concerned that affirmance of the decision below will have a devastating and unfair impact on individual workers. At a time when an employee has been ill or seriously injured due to the fault of a third party, court should not invite aggressive collection efforts by plan fiduciaries, insurers, and the recoupment industry.

SUMMARY OF ARGUMENT

1. The court below held that the ERISA plan could sue participant Mr. Montanile for reimbursement of medical benefits, despite the fact that the plan had agreed to obtain reimbursement only out of the proceeds obtained from a third party responsible for the injury and despite the fact that Montanile had already dissipated those funds. The Eleventh Circuit held that, once the plan's equitable lien by agreement attached to the settlement funds, subsequent dissipation of those funds was of no consequence.

A cornerstone precept in this Court's ERISA jurisprudence is that Congress limited fiduciaries suing under ERISA, § 502(a)(3), 29 U.S.C. § 1132(a)(3), to relief that was typically available in equity. A fiduciary may enforce a contract provision for reimbursement of health care benefits by imposing an equitable lien on recoveries from third party tortfeasors. Congress did not authorize a fiduciary to

sue a participant for personal liability for breach of contract, a remedy at law.

The Eleventh Circuit's ruling, and similar holdings by five other federal circuit courts of appeals, misreads this Court's discussion of "tracing" in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356, 364-65 (2006). The Court there explained that a plaintiff asserting a restitutionary equitable lien to restore property to plaintiff must show that the attached property is, or can be traced to, property in the *plaintiff's* hands, a requirement that does not apply to equitable liens by agreement. The lower court, however, conflated that requirement with a similar tracing rule that does apply to liens by agreement. If the defendant has exchanged the res for other property, the lienholder may transfer the lien to the new property or to the old property in the hands of a new owner. In either instance, the plaintiff must trace the property sought to be recovered back to the initial res in the *defendant's* hands.

But there must be a res. A fundamental rule of equity is that an equitable lien lives only so long as the res remains intact. This principle applied to restitutionary equitable liens as well as to liens created by contract. Nothing in *Sereboff* suggests otherwise.

2. Nor would extending the plan's right of reimbursement to reach an individual participant's general assets inure to the benefit of the other plan members. Proponents have contended that repayment of medical benefits from tort proceeds reduces the health care premiums for all plan participants. However, a large percentage of recovered funds is paid over to recoupment firms that locate and collect such

reimbursements. In addition, most reimbursements do not go directly into plan assets, but rather to insurance companies that operate fully insured plans or that provide stop-loss coverage for self-funded plans. Reimbursements are not factored into the insurers' ratemaking process, but are often diverted to other purposes, including shareholder dividends and executive compensation.

Even if reimbursed benefits were devoted entirely to reducing premiums, the average savings per covered participant would amount to less than one-tenth of one percent. More fundamentally, the purpose of insurance is to spread the risk of a large and unexpected loss over a pool of participants through the assessment of premiums. Shifting large losses from the pool of participants onto the shoulders of a few injured individuals in order to lower premiums is insurance running in reverse.

3. Expanding the equitable relief available to a fiduciary to include recovery from a participant's general assets is unnecessary to protect the plan's reimbursement rights. The plan could assert its own right of subrogation to recover from the third party directly, or it could intervene in the participant's lawsuit. The plan also has the option of compromising for less than full reimbursement when the third party settlement is inadequate. Fears that participants will quickly dissipate settlement proceeds to avoid their plan obligations are overblown. Those funds are paid over to the participant's counsel, who is bound by professional ethics rules to protect the interests of the holders of valid liens.

At the same time, expanding the reach of plan reimbursement to allow recovery from a participant's

general assets would weaken the plan's incentive to settle its reimbursement claims promptly and to compromise when third party funds are insufficient. Affirmance by the Court in this case will invite more aggressive recovery tactics on the part of plans and recoupment companies. For example, plans may provide in their reimbursement "agreements" for recovery against a participant's other assets when the third-party tort settlement does not fully repay the plan.

Many plan participants will simply reject the option of suing a responsible third party if there is a real prospect they could prevail but recover nothing or perhaps even become financially worse off. Attorneys, too, will decline cases in which there are large ERISA-covered medical costs. Thus, the result of the aggressive recoupment efforts pursued in this case will be far fewer recoveries by ERISA plans.

ARGUMENT

I. The Court Below Misapplied the Principles of Equitable Relief Discussed by This Court in *Sereboff*.

The American Association for Justice respectfully addresses this Court regarding the single issue presented in this case: Whether an ERISA fiduciary can bring suit under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), to hold a plan participant personally liable for repayment of health care benefits where the plan provided for reimbursement solely out of tort proceeds that the participant has dissipated. The American Association for Justice urges this Court to reject the lower court's drastic expansion of the expressly limited equitable relief provided to

fiduciaries by Congress. Permitting the plan to satisfy its reimbursement claim out of other property of the participant is not authorized by the contract in this case and contravenes this Court's clear precedents regarding the scope of relief permitted by § 502(a)(3).

A. The lower court's drastic expansion of the plan's equitable lien on tort settlement funds to reach a participant's general assets was based on an erroneous reading of remarks in *Sereboff* concerning "tracing."

A cornerstone precept in this Court's ERISA jurisprudence is that Congress limited fiduciaries suing under ERISA, § 502(a)(3), 29 U.S.C. § 1132(a)(3) to "appropriate equitable relief" that was "typically available in equity" in the days of "the divided bench." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993). In *Great-W. Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), this Court held that such relief could include a restitutionary equitable lien for reimbursement of benefits from a tort award, so long as those funds were within the possession and control of the defendant. *Id.* at 213-14. The Court in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), permitted the fiduciary to enforce an equitable lien based on an agreement to reimburse the plan out of proceeds of a tort award that the Sereboffs had preserved in a separate investment account. *Id.* at 363-64. Similarly, in *U.S. Airways, Inc. v. McCutchen*, --- U.S. ----, 133 S. Ct. 1537 (2013), this Court held that a plan could impose an equitable lien on tort proceeds held in a separate account, after reduction for the plan's share of compensation for the attorney who obtained the fund. *Id.* at 1543. The parties agreed

that, as in *Sereboff*, the plan "could bring an action under § 502(a)(3) seeking *the* funds that its beneficiaries had promised to turn over." *Id.* at 1545 (emphasis added).

In each instance, the availability of the equitable remedy necessarily depended upon the continued existence of the fund to which that lien attached. As in the days of the divided bench, if that res is no longer intact, plaintiff continues to have a contract right to reimbursement, but the remedy of an equitable lien no longer is available. Justice Scalia, writing for the Court in *Knudson*, made clear this fundamental principle:

> [W]here "the property [sought to be recovered] or its proceeds have been dissipated so that no product remains, [the plaintiff's] claim is only that of a general creditor," and the plaintiff "cannot enforce a constructive trust of or an equitable lien upon other property of the [defendant]."

534 U.S. at 213-14 (quoting *Restatement (First) of Restitution*, § 215, Comment a, at 867 (1937)).

In this case, Mr. Montanile was a participant in the National Elevator Industry Health Benefit Plan, administered by Respondent Trustees. Pet. App. 1-2. In 2008, he was seriously injured in an auto accident by a drunk driver, and the Plan paid his initial medical expenses of $121,044. *Id.* at 6. He retained a trial lawyer who obtained a financial settlement of his claims against the other driver. *Id.* Montanile also retained an experienced ERISA attorney to reach an accommodation with the Trustees regarding the

Plan's claims for reimbursement under the terms of the Summary Plan Description. Pet. 12. Negotiations were not successful and the Trustees filed this action on July 11, 2012. *See* Pet. App. 23-25. By that time, however, Montanile had used up most of the remaining settlement funds to pay bills and care for himself and his young daughter. Pet. 12.

The magistrate judge granted summary judgment in favor of the Trustees for the entire amount sought in reimbursement, despite the fact that the fund identified in the SPD as the sole source of reimbursement was no longer in Montanile's possession, and was not in anyone's possession as an identifiable fund. The district court acknowledged the Eleventh Circuit's previously stated position that "[u]nder *Knudson* [and] *Sereboff* the most important consideration is not the identity of the defendant, but rather *that the settlement proceeds are still intact*, and thus constitute an identifiable res.' Pet. App. 39 (quoting *Admin. Comm. for Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Horton*, 513 F.3d 1223, 1229 (11th Cir. 2008)). Nevertheless, the magistrate judge stated that the Eleventh Circuit had not "had occasion to address this issue of dissipation." *Id.*

Instead, the magistrate judge found "particular significance" in *Sereboff's* statement that the "strict tracing rules" required for restitutionary equitable liens do not apply to equitable liens by agreement. *See id.* at 36-38 (citing *Sereboff*, 547 U.S. at 365). The magistrate judge embraced what he perceived as "the majority view" that, under *Sereboff*, "a beneficiary's dissipation of assets is immaterial when a fiduciary asserts an equitable lien by agreement." *Id.* at 40. All that was required, the magistrate judge stated, was

that Montanile had notice of the reimbursement obligation and had possessed the funds at some point. *Id.* at 43-44.

The Eleventh Circuit affirmed without extended discussion, relying on its recent holding in *AirTran Airways, Inc. v. Elem*, 767 F.3d 1192 (11th Cir. 2014). There, the Eleventh Circuit stated that "[i]n *Sereboff*, the Supreme Court made clear that AirTran need not trace the settlement fund back to AirTran to enforce its equitable lien by agreement." *Id.* at 1198. The court concluded that "[i]t matters not whether the settlement funds have since been disbursed or commingled with other funds." *Id.* The court added that a majority of federal circuits had similarly interpreted this Court's tracing discussion in *Sereboff*. *Id.* *See Cusson v. Liberty Life Assur. Co. of Boston*, 592 F.3d 215, 231 (1st Cir. 2010) (allowing ERISA to recover overpayment of long-term disability benefits years after their original payment, even though "Liberty has not identified a specific account in which the funds are kept or proven that they are still in Cusson's possession" (citing *Sereboff*)); *Thurber v. Aetna Life Ins. Co.*, 712 F.3d 654, 664 (2d Cir. 2013) (ERISA plan may seek return of overpayments of disability benefits "whether or not the beneficiary remains in possession of those particular dollars" (citing *Sereboff*)); *Funk v. CIGNA Group Ins.*, 648 F.3d 182, 194 (3d Cir. 2011) (ERISA plan could recover overpaid disability benefits and, under *Sereboff*, if "there was an equitable lien by agreement dissipation of the funds [is] immaterial."); *Longaberger Co. v. Kolt*, 586 F.3d 459, 466-67 (6th Cir. 2009) (plan could recover reimbursement of medical benefits based on equitable lien on tort settlement funds, despite the fact that most of the funds had been disbursed, relying on *Sereboff*'s rejection of tracing

requirement); *Gutta v. Standard Select Trust Ins. Plans*, 530 F.3d 614, 621 (7th Cir. 2008) (plan may recover overpayments of disability benefits based on equitable lien by agreement, even though "the benefits it paid Gutta are not specifically traceable to Gutta's current assets because of commingling or dissipation" (citing *Sereboff*)). The Trustees in this case also rely on this interpretation of *Sereboff*. Br. for Resp't on Pet. 17.

This is a plain misreading of Chief Justice Roberts's opinion. In addressing the Sereboffs' objections, he acknowledged that when an equitable lien is imposed as a restitutionary remedy to restore a thing unlawfully taken from the plaintiff, the plaintiff must be able to "trace *his* [plaintiff's] money or property to some particular funds or assets" that plaintiff seeks as restitution. 547 U.S. at 364-65. An equitable lien by agreement, however, is a "different species of relief." *Id.* at 365. Chief Justice Roberts pointed to the example of *Barnes v. Alexander*, 232 U.S. 117 (1914), where attorneys Street and Alexander were held to have an equitable lien on a portion of a contingency fee obtained in a case by Barnes, based on the attorneys' agreement. As the Chief Justice noted, Street and Alexander "could not identify an asset they originally possessed, which was improperly acquired and converted into property the defendant held, yet that did not preclude them from securing an equitable lien." 547 U.S. at 365. Similarly, he wrote for the Court, the fact that Mid Atlantic was not seeking restoration of property that it once possessed was "of no consequence." What was essential was that Mid Atlantic sought recovery from an "equitable lien on a specifically identified fund, not from the Sereboffs' assets generally, as would be the case with a contract action at law." *Id.* at 362-63.

Nothing in this discussion casts doubt on the proposition highlighted by Justice Scalia in *Knudson*, 534 U.S. 204, that an equitable lien lives only so long as the thing that is subject of the lien remains intact and that "where the property [sought to be recovered] or its proceeds have been dissipated," plaintiff's remedy is at law, not in equity. *Id.* at 213-14. This is not a principle of restitution; it is an essential feature of equitable liens generally.

The lower courts have erroneously conflated the "strict tracing rules" applicable to a lien to restore property wrongfully taken from the plaintiff, which must be traced back to *plaintiff's* hands, with a separate requirement applicable to equitable liens based on contract, where the holder of the identified res has exchanged it for other property. The plaintiff may impose the lien on the new property. *Restatement (First) of Trusts* § 202(1) (1935) ("Where the trustee by the wrongful disposition of trust property acquires other property, the beneficiary is entitled to enforce an equitable lien upon it as long as the product of the trust property is held by the trustee and can be traced.").

Similarly, if the trustee has transferred the res to a third party, the lienholder could recover that property, unless the third party were a bona fide purchaser without notice of the lien. *Restatement (First) of Restitution* § 161, comment d (1937) ("If property which is subject to an equitable lien is transferred to a third person who has notice of the equitable lien or who does not give value, the equitable lien can be enforced against the property in the hands of the third person.").

In either instance, the lienholder must trace the sought-after property back to the original property that was subject to an equitable lien in the *defendant's* hands.

But the res must remain intact, not only when the lien is created, but later when plaintiff seeks its enforcement. "An equitable lien can be established *and enforced* only if there is some property which is subject to the lien." *Restatement (First) of Restitution* § 161, comment e (1937) (emphasis added). Barnes could well have traded the promised portion of the contingency fee for a fine wine, which the attorneys could recover from Barnes or from a transferee with notice. But if Barnes had drunk it or poured it down the drain, the attorneys would have a legal claim for breach of contract against Barnes, not an equitable lien on his other property.

National City Bank of New York v. Hotchkiss, 231 U.S. 50 (1913), which the Court in *Barnes v. Alexander* relied upon, 232 U.S. at 121, stands for just this principle. In that case, where funds loaned to a broker were commingled with the bank's general assets, the bank lost its equitable lien and became a general creditor. As Justice Holmes explained, "A trust cannot be established in an aliquot share of a man's whole property, as distinguished from a particular fund, by showing that trust moneys have gone into it. . As all trace of the bank's money was lost when it entered the stream of the firm's general property, there can be no right of subrogation." 231 U.S. at 57-58.

The Ninth, Eighth, and Fifth Circuits properly reject the misinterpretation of *Sereboff* advocated by Respondent and the court below. *See Bilyeu v. Morgan*

Stanley Long Term Disability Plan, 683 F.3d 1083, 1095 (9th Cir. 2012) ("Nothing in *Sereboff* suggests that a fiduciary can enforce an equitable lien against a beneficiary's *general assets* when specifically identified funds are no longer in a beneficiary's possession."); *Treasurer, Trustees of Drury Indus., Inc. Health Care Plan & Trust v. Goding*, 692 F.3d 888, 896-97 (8th Cir. 2012) (*Knudson* and *Sereboff* allow an ERISA plan to recover on an equitable lien on "specifically identifiable funds that [are] within the possession and control of [the defendant]," but do not permit personal liability after those funds have been disbursed); *ACS Recovery Servs., Inc. v. Griffin*, 723 F.3d 518, 527 (5th Cir. 2013) (en banc), *cert. denied sub nom. Larry Griffin Special Needs Trust v. ACS Recovery Servs., Inc.*, --- U.S. ----, 134 S. Ct. 618 (2013) (ERISA plan could recover on an equitable lien by agreement from a third-party special needs trust. "Under *Knudson*, [and] *Sereboff*, the most important consideration is not the identity of the defendant, but rather that the settlement proceeds are still intact.").

B. An equitable lien was an available remedy only so long as the rest remained intact.

In the days of a "divided bench" it was well settled that an equitable lien was a typically available remedy only so long as the res to be recovered remained identifiably intact. Professor Pomeroy declared this to be an essential feature of equitable liens created by a contract:

> [E]quity recognizes, *in addition to the personal obligation*, a peculiar right over the thing concerning which the contract

> deals, which it calls a "lien," . . . by means of which the plaintiff is enabled to follow *the identical thing*, and to enforce the defendant's obligation by a remedy *which operates directly upon that thing*.

4 John N. Pomeroy, *A Treatise on Equity Jurisprudence* § 1234 (Spencer W. Symons ed., 5th ed. 1941) (emphasis added). Such an equitable lien by agreement "is enforceable against the *property in the hands* not only of the original contractor" but also in the hands of purchasers with notice. *Id.* at § 1235 (emphasis added).

As noted earlier, equity might extend such liens to reach new property or a new owner, if the property to be attached can be traced to the initial res in the hands of the *defendant*.

> No change in the form of the trust property, effected by the trustee, will impede the rights of the beneficial owner to reach it and to compel its transfer, *provided it can be identified as a distinct fund*, and is not so mingled up with other moneys or property that it can no longer be specifically separated.

3 Pomeroy, *supra*, at § 1058 (emphasis added).

This rule was primarily concerned with avoiding the unfairness to other creditors that would result from allowing one creditor who had agreed to repayment solely out of a particular fund or asset that has dissipated to recover from the debtor's other assets.

> Thus, if the trustee sells trust property and dissipates the proceeds, the beneficiary is not entitled to priority over other creditors of the trustee. The beneficiary is entitled to priority only if and to the extent that he can trace the trust property into a product. *He must prove not only that the trustee once had the trust property or its product, but that he still holds the trust property,* or property which is in whole or in part the product of the trust property. But *if it is shown that the property or its proceeds has been dissipated so that no product remains . . his claim is only that of a general creditor* of the trustee.

Restatement (First) of Trusts § 202, comment o (1935) (emphasis added). The scope of equitable relief available under § 502(a)(3) is no broader.

II. Extending the Plan's Right of Reimbursement to Reach a Participant's General Assets Will Not Benefit Plan Participants and Will Not Further the Purpose of Congress in Enacting ERISA.

A. Expanding the reimbursement remedies permitted to ERISA plans will not significantly benefit plan participants.

Respondent argued to the court below that holding a participant personally liable for reimbursement of benefits if the proceeds of a tort award have been dissipated is "better policy": Otherwise the unreimbursed "cost of medical

treatment caused by third parties would be absorbed by all plan members and beneficiaries through higher contributions and premiums." Br. of Plaintiff-Appellee, *Health Benefit Plan v. Montanile*, 593 Fed. Appx. 903 (11th Cir. 2014) (No. 14-11678), 2014 WL 3384838, at *32-33. In this Court, Respondent contends that the position of the Eighth and Ninth Circuits, limiting the Plan's reimbursements to the identifiable tort proceeds, "will cost plans a portion of those reimbursements, [which] will have to be passed along to others." Br. for Resp't on Pet. 15. There is no evidence, and Respondent suggests none, that health insurance premiums are in fact costlier in those circuits which limit reimbursements.

Nevertheless, other courts have echoed the claim that reimbursement inures to the benefit of all participants and beneficiaries by keeping premiums low. *See, e.g., Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1237-38 (11th Cir. 2010) ("If O'Hara were relieved of his obligation to reimburse Zurich for the medical benefits it paid on his behalf, the cost of those benefits would be defrayed by other plan members and beneficiaries in the form of higher premium payments."); *Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Shank*, 500 F.3d 834, 838 (8th Cir. 2007) (similar); *Schwade v. Total Plastics, Inc.*, 837 F. Supp. 2d 1255, 1278 (M.D. Fla. 2011) ("If a plan cannot trust a court to enforce a subrogation right, a beneficiary cannot receive lower premiums."). This Court in *Sereboff* heard similar pleas from ERISA fiduciaries. *See* Brief of Resp'ts, *Sereboff v. Mid-Atlantic Med. Servs., Inc.*, 547 U.S. 356 (2006) (No. 05-260), 2006 WL 467696, at *33. No explanation of how such discounting occurs or a single example documenting an ERISA plan's reduction of

premiums as a result of obtaining reimbursement has been forthcoming.

The explanation offered by the Solicitor General was that "an employer who self-insures directly reduces its costs by recovering those costs from a third-party." Br. for the United States as Amicus Curiae, *Sereboff v. Mid-Atlantic Med. Servs., Inc.* 547 U.S. 356 (2006) (No. 05-260), 2006 WL 460876, at *26 n.10. However, as the United States acknowledged, only 300,000 of 2.5 million ERISA plans are self-insured. *Id.* Two-thirds of those are partially insured by stop-loss insurance. Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2014 Annual Survey* 174 (2014), *available at* http://ehbs.kff.org. Thus, for some 96 percent of all plans, reimbursements of any appreciable size will not go directly into plan assets to reduce the fund's costs, but will go to an insurance company. The United States added that limiting reimbursement "necessarily imposes higher costs on insurers and . insured plans as well." *Id.* But this Court should not simply assume that reducing an insurance company's insurer's costs by expanding reimbursement "necessarily" translates into lower premiums. There are plenty of uses for found money.

One amicus brief in *Sereboff* did contend: "Reimbursement and subrogation results are factored into claims experience" which is used by insurers and plans as a basis for setting rates. Amicus Curiae Br. of America's Health Ins. Plans, Inc., *et al.*, *Sereboff v. Mid Atlantic Medical Service, Inc.*, 547 U.S. 346 (2006) (No. 05-260), 2006 WL 460877, at *14-15 & n.19. However, the sole support offered for this proposition was Actuarial Standard of Practice No. 5,

Incurred Health and Disability Claims, which states that an actuary "should take into account the relevant organizational practices and regulatory requirements related to subrogation." *Id.* at 15 n.19. The standards themselves state that they "seek to define an appropriate level of practice" but do not necessarily reflect current practices. Actuarial Standard of Practice No. 1. The amici offered no evidence that the standard is actually followed by ERISA health plans or that it has ever resulted in a reduction in ERISA plan premiums.

To the contrary, there is substantial scholarship indicating that health insurance "premiums themselves are calculated based upon the losses actually incurred, and do not take subrogation recoveries into account." Keith E. Edeus, Jr., *Subrogation of Personal Injury Claims: Toward Ending an Inequitable Practice*, 17 N. Ill. U. L. Rev. 509, 514-15 (1997). *See also* John F. Dobbyn, *Insurance Law in a Nutshell* 384 (4th ed. 2003) (subrogation has not reduced insurance rates because "[i]nsurers consistently fail to introduce the factor of such recoveries into rate-determining formulae"); Roger M. Baron, *Public Policy Considerations Warranting Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom*, 55 Mercer L. Rev. 595, 627-31 (2004) (insurers do not consider subrogation when setting insurance rates).

Clear evidence of this can be seen by comparing the rate experience of fully insured ERISA plans, which are subject to state insurance law restrictions on reimbursements and subrogation, with self-insured plans. Most states have anti-subrogation laws, follow the "make whole" doctrine, award

attorney fees based on the common-fund rule, or impose other restrictions on insurers' recovery of reimbursements. Roger M. Baron & Anthony P Lamb, *The Revictimization of Personal Injury Victims by ERISA Subrogation Claims*, 45 Creighton L. Rev. 325, 330 (2012). *See generally*, Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723 (2005) (providing a state-by-state overview). These regulations are applicable to fully insured ERISA plans. *See FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

If the theory were true that restricting ERISA plan reimbursements would cause plan premiums to skyrocket, then we would expect fully insured plans to experience higher rate increases than self-funded plans which are shielded from state insurance law. Instead, according to the authoritative Kaiser Family Foundation survey, the increases in premiums for employee health benefits has been about the same. In fact, the average family premium charged by self-insured plans increased by 73% from 2004 to 2014. Premiums rose only 71% for fully insured plans. *Employer Health Benefits: 2014 Annual Survey*, *supra*, at 21.

If the theory were true, we would also expect to see two groups of competing plans in the insurance market: one at a higher price which does not include reimbursement provisions and another providing the same coverage at a lower premium discounted for the reimbursement savings. Instead, the reimbursement requirement is universal; no-subrogation medical insurance policies are essentially absent from the marketplace, strongly indicating that reimbursements have negligible impact on premiums.

Brendan S. Maher & Radha A. Pathak, *Understanding and Problematizing Contractual Tort Subrogation*, 40 Loy. U. Chi. L.J. 49, 85 (2008).

Where does the reimbursement money go? A portion, of course, goes to the recoupment industry itself. Most companies specializing in subrogation services for health benefit plans "charge based on a tiered pricing model, which can range from 20-40%" of the recovery. Sedgwick Claims Management Services, *Central Subrogation* (2012), *available at* https://www.sedgwickcms.com/services/docs/SubrogationOverview.pdf. It is a $200 million to $400 million industry.[2]

As for the remainder, the "general consensus among legal scholars is this revenue does not flow to the benefit of consumers by reducing insurance rates, but rather increases executive compensation and shareholder payouts." Roger M. Baron & Delia M. Druley, Trial, Journal of the Minnesota Association for Justice, *ERISA Reimbursement Proceeds: Where Does the Money Go?* 10 (Spring 2010). *See also* Dobbyn, *supra*, 384 (Insurers "apply such recoveries to increasing dividends to shareholders"); Scott M. Aronson, *ERISA's Equitable Illusion: The Unjustice of Section 502(a)(3)*, 9 Emp. Rights & Emp. Policy J. 247, 286 (2005) ("Subrogation recoveries are used to

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[2] ERISA plans and related insurers "are collecting in excess of $1 billion annually through the seizure of tort recoveries intended for personal injury victims." Baron & Lamb, *supra*, at 325. Professor Baron asks: "Does society want to provide jobs for bill collectors that are funded by tort recoveries of innocent victims who have suffered catastrophic losses?" Baron, *supra*, at 621.

increase executive compensation or shareholder dividends, not to decrease premiums.").

Even if the amounts recovered by plan fiduciaries in reimbursement were devoted entirely to reducing premiums, the monetary benefit to the average plan participant would be vanishingly small.

Respondent points to industry estimates that "plans recover more than $1 billion annually under reimbursement provisions." Br. for Resp't on Pet. 15. This is admittedly a substantial sum. But, as the Department of Labor reports, ERISA plans provide health care benefits to "some 137 million Americans." U.S. Dep't of Labor, Employee Benefits Security Administration, *Factsheet: Workers' Right to Health Plan Information*, http://www.dol.gov/ebsa/newsroom/fserisa.html (last visited July 10, 2015). The average annual premium for a single employee is $6,025. *Employer Health Benefits, 2014 Annual Survey*, *supra*, at 20. Assuming only 20% is paid to the recoupment company, the reduction in premiums would amount to a miniscule $5.84 per covered person per year, less than one-tenth of one percent of the average annual premium.[3]

Petitioner in this case does not ask this Court to prohibit reimbursement provisions altogether, but only to preclude imposing personal liability in the small fraction of reimbursements where the

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[3] This calculation comports with other recent estimates. *See, e.g.*, E. Farish Percy, *Applying the Common Fund Doctrine to an ERISA-Governed Employee Benefit Plan's Claim for Subrogation or Reimbursement*, 61 Fla. L. Rev. 55, 97 (2009) ("[T]he largest provider of subrogation services reported that . . . [it] recover[ed] an average of $4.80 in subrogation and reimbursement per covered person per year.").

participant or beneficiary has dissipated the tort recovery. The argument that allowing the fiduciary to obtain reimbursement from other assets is necessary to the viability of the plan or would confer any benefit on the other plan participants is risibly overblown.

B. Shifting the burden of large losses to individual beneficiaries in order to lower premiums by a tiny amount is the opposite of insurance and does not further the Congressional aim for ERISA.

The deeper difficulty with Respondent's argument lies in its rejection of the very purpose of insurance, which is to spread the risk of large losses over a large pool of participants. The court below echoed the defective reasoning voiced by the appellate court in *Administrative Comm. of Wal-Mart Stores, Inc. Associates' Health & Welfare Plan v. Shank*, 500 F.3d 834 (8th Cir. 2007), where a vehicle accident left Deborah Shank permanently brain-damaged and in a wheelchair. Her tort settlement was woefully inadequate for her medical costs, but was placed in a special needs trust for her future care. The Wal-Mart ERISA plan that had paid her past medical expenses demanded the entire trust amount in reimbursement. The Eighth Circuit acquiesced:

> We acknowledge the difficulty of Shank's personal situation, but we believe the purposes of ERISA are best served by enforcing the Plan as written. Shank would benefit if we denied the Committee its right to full reimbursement, but all other plan

> members would bear the cost in the form of higher premiums.

Id. at 838.[4]

Congress did not intend for ERISA plans to save on premiums for the plan members as a group at the expense of the individual members who have need of the health benefits they have paid for. "The primary purpose of [ERISA] is the protection of *individual* pension rights." H.R. Rep. No. 93-533, pt. 1 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4639, 1973 WL 12549.

The argument for aggressive enforcement of reimbursement provisions is that the pool of plan participants must be shielded from relatively small premium costs, even if large losses are thereby shifted to injured individual participants. This is not the purpose of ERISA. This is insurance running in reverse.

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[4] Due to the outrage generated by this result, "Wal-Mart eventually caved to public pressure and agreed to allow the money to remain in the special trust." *See* Brendan S. Maher & Radha A. Pathak, *Understanding and Problematizing Contractual Tort Subrogation*, 40 Loy. U. Chi. L.J. 49, 49 & n.1 (2008).

III. Expanding "Appropriate Equitable Relief" to Include Plan Reimbursement Out of a Participant or Beneficiary's General Assets Is Unnecessary to Protect Plans' Reimbursement Rights and Would Undermine the Congressional Purpose of Fostering Employee Benefit Plans.

A. Imposing personal liability on an ERISA plan participant or beneficiary for reimbursement is unnecessary.

The Trustees argue that failure to allow a plan to satisfy its claim to reimbursement from Montanile's general assets would offend the maxim that "[e]quity suffers not a right to be without a remedy." Br. for Resp't on Pet. 20 (quoting *CIGNA Corp.* v. *Amara*, --- U.S. ----, 131 S. Ct. 1866, 1879 (2011)).

To the contrary, as professor Pomeroy made clear, an equitable lien by agreement is not a right; it is a remedy. It allows the plaintiff to enforce some primary right against a particular thing or fund "rather than [providing] a right to recover a sum of money generally out of the defendant's assets. Pomeroy, *supra*, at § 1234. Here, the plan seeks to enforce a contract right to reimbursement. The remedy of an equitable lien on settlement funds is not available when the specified fund is no longer intact. Nevertheless, the plan has an array of options to protect its right to reimbursement.

The plan can assert its right of subrogation and file its own action against the tortfeasor for the amount of the lien, returning any excess to the beneficiary. Secondly, the plan can intervene in the

action filed by its beneficiary and participate in settlement negotiations to insure its reimbursement rights are protected. Third, where, as here, the beneficiary is unable to obtain full compensation from the tortfeasor, the plan can compromise with its beneficiary on a lower reimbursement, rather than litigate for the full amount, with the attendant risk of loss or inability to collect on a judgment. *See* Peter H. Wayne & Mark R. Taylor, *Beware the ERISA Health Plan Lien*, 43 Trial 48, 54 (2007) (recommending to trial lawyers a strategy of "cooperative negotiation").

The plan insists, however, that failure to impose personal liability on a participant who has dissipated the settlement proceeds sets up a perverse incentive for plan beneficiaries "to spend every dollar of settlement funds immediately upon receipt." Br. for Resp't on Pet. 15.

This, as trial lawyers well know, is simply not based in reality. The rules of professional conduct in every state require an attorney to hold tort proceeds subject to valid liens in trust accounts and preclude their disbursement to the client even upon the client's demand. *See, e.g.*, Virginia Legal Ethics Opinion 1747, *Attorney Breaching Contract to Pay Medical Bills Out of Settlement Proceeds*, ("A lawyer owes an ethical duty under Rule 1.15 (c) (now Rule 1.15(b)) to protect the rights of a health care provider to settlement proceeds under client's assignment of funds executed in favor of the health care provider."); California Formal Ethics Opinion 1988-101 (lawyer whose client had agreed to pay recovery proceeds to health care provider may not ignore the agreement and disburse funds to client); Maryland Ethics Opinion 94-19 (1992) (same).

Attorneys are aware of their ethical obligations and have little to gain and much to lose by disbursing to clients settlement funds that are subject to valid ERISA plan liens. *See* Wayne & Taylor, *supra*, at 49. Expanding the equitable lien to allow personal liability of a client who has dissipated funds is simply unnecessary.

B. Imposing personal liability on ERISA participants and beneficiaries will ultimately increase the costs of ERISA plans.

Allowing plan fiduciaries to recover reimbursement out of the general assets of a participant or beneficiary carries perverse incentives of its own.

It is an unhappy fact that tort recoveries often do not fully compensate wrongfully injured plaintiffs. Indeed, "scholarly research documents that more seriously injured victims tend to recover only a part of their total financial losses, notwithstanding the supposed legal entitlement to full compensation." Kenneth S. Abraham, Robert L. Rabin & Paul C. Weiler, *Enterprise Responsibility for Personal Injury: Further Reflections*, 30 San Diego L. Rev. 333, 340 (1993). In fact, the consistent "undercompensation [of personal injury plaintiffs] at the higher end is so well replicated that it qualifies as one of the major empirical phenomena of tort litigation." Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System–And Why Not?* 140 U. Pa. L. Rev. 1147, 1218 (1992).

The court below, in ordering Montanile to reimburse the plan out of funds that were not

identified in the SPD as the source of reimbursement, drastically expands the reach of reimbursement with troublesome consequences. First, the potential availability of participant's general assets removes the plan's incentive to resolve repayment issues promptly and to compromise its reimbursement claim when tort funds are insufficient.

Affirmance in this case may lay the foundation for plans to engage in even more aggressive recoupment practices. For example, if this Court agrees with the Trustees that such personal liability is "appropriate equitable relief," future plans may insert provisions into health benefit plans imposing a contract obligation on beneficiaries to satisfy any deficiency in settlement funds out of their other assets. Plan participants who have been injured by third parties would face the very real prospect of recovering little or even becoming financially worse off after winning their tort case than if they had never brought suit.

That situation obviously cannot be sustained. Many of those wrongfully injured will simply decide not to pursue claims against their tortfeasors, particularly if they have large medical expenses paid by their ERISA plan. Maher & Pathak, *supra*, at 88. The prospect that the plan could take everything won from the wrongdoer *plus* the employee's savings, retirement funds, or other assets would be unbearable. Attorneys, too, will decline to accept such cases. *See* Karen Ertel, *Insurer May Take Share of Damages Award, Supreme Court Rules*, 42 Trial 92, 92 (July 2006).

The primary beneficiaries of expanding the reimbursement reach of plan fiduciaries, in the long

run, will be those individuals or companies who negligently injure or kill and who will not be held accountable. To the extent that accountability for negligence promotes safety, such a rule may lead to increased accident rates and greater medical care claims. At the same time, as a consequence of fewer third-party lawsuits against responsible companies and individuals, the stream of reimbursement money will begin to dry up.

Employees will suffer the greatest adverse impact of more aggressive recoupment efforts. They will continue to lose protection under a law its primary sponsor declared to by "the greatest development in the life of the American worker since Social Security." 120 Cong. Rec. 29, 933 (1974) (statement of Sen. Jacob Javits). They have no voice in choosing the plan or crafting its terms. Yet courts bind employees to plan terms as though they had agreed to them in an arm's length transaction. If the plan pays their medical expenses after an accident, they often find that "coverage" they paid for is treated as a loan to tide them over until a personal injury attorney, paid for entirely by the employee, can obtain an inadequate tort settlement to be turned over to the plan. This Court should not construe ERISA to permit illusive coverage for plan participants and beneficiaries.

CONCLUSION

For the foregoing reasons, the American Association for Justice urges this Court to reverse the judgment below.

July 13, 2015

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No. 14-723

IN THE

Supreme Court of the United States

ROBERT MONTANILE,
Petitioner,

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* IBEW-NECA SOUTHWESTERN HEALTH & BENEFIT FUND AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA SUPPORTING RESPONDENT

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QUESTION PRESENTED

Whether a beneficiary of a benefit plan governed by the Employee Retirement and Income Security Act of 1974 (ERISA) can defeat enforcement of the plan's valid equitable lien by agreement—after the lien attached—by spending the funds subject to the lien.

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BRIEF OF *AMICI CURIAE* THE IBEW-NECA SOUTHWESTERN HEALTH & BENEFIT FUND AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA SUPPORTING RESPONDENT

INTEREST OF *AMICI CURIAE*[1]

The IBEW-NECA Southwestern Health & Benefit Fund ("the Fund") is a self-funded multiemployer welfare benefit plan subject to regulation under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* The International

[1] All counsel of record consented to the filing of this brief by filing blanket consents with the Clerk. *Amici* state that no portion of this brief was authored by counsel for a party and that no person or entity other than *amici*, their counsel, or their members made a monetary contribution intended to fund the preparation or submission of this brief.

Brotherhood of Electrical Workers, a union with approximately 750,000 members, created the Fund to provide benefits to many of its members. The Fund pays out substantial benefits each year, but only on the condition that injured participants or beneficiaries will reimburse the Fund if they recover the same expenses from responsible third parties.

The Chamber of Commerce of the United States of America ("the Chamber") is the world's largest business federation. It represents 300,000 direct members and indirectly represents the interests of more than three million businesses and organizations of every size, in every sector, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files *amicus curiae* briefs in cases that raise issues of vital concern to the Nation's business community.

This case concerns the circumstances under which a plan fiduciary can bring a civil action under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), to enforce its reimbursement rights for plan-paid medical expenses. Reimbursement provisions serve a vital role in limiting a plan's costs and preserving its ability to provide meaningful benefits to all participants. When costs rise, plans face pressure to increase everyone's plan contributions or reduce the overall level of benefits. Reimbursement provisions restore balance to a plan's promise to provide medical coverage to its participants: those participants receive immediate payment of their medical expenses in return for the participant repaying the plan in the event of a subsequent recovery from responsible third parties. This upfront bargain guarantees that plan assets are preserved for all participants and avoids the inequitable windfall of a double recovery—a beneficiary's attempt to

collect medical expenses once from the plan and again from responsible third parties. Due to obvious fiscal considerations—and common notions of fairness—these provisions are ubiquitous in ERISA-regulated employee-benefit plans, including the Fund and many of the plans of the Chamber's members.

Amici have a strong interest in this case because of the costs that would result if plan beneficiaries are allowed to accept plans' medical benefits without also accepting their corresponding reimbursement obligations. If Petitioner's self-interested loophole is allowed to stand, reimbursement will be transformed into an empty obligation. Beneficiaries will be able to avoid their reimbursement obligations by quickly spending any tort recoveries on consumable or intangible goods or services. That result would undermine the long-term financial health of ERISA plans, increase the costs of providing benefits to all participants, and impair each plan's ability to maintain existing benefit levels without demanding additional contributions from employers and employees alike.

SUMMARY OF ARGUMENT

Nearly half of Americans rely on ERISA health and benefit plans to protect them in their darkest hours. These not-for-profit plans provide much needed financial support in times of great stress and tragedy. In doing so, the plans shield their participants from the devastating financial burdens that often accompany severe injuries and illnesses. But these plans can fulfill that vital function only if they remain financially solvent. Part of maintaining their financial health comes from receiving contributions from participants and their employers. Also important are the reimbursements that plans receive from the third parties responsible for their participants' injuries.

This latter funding stream is what is at stake here. Health and welfare plans immediately pay the medical

expenses of a plan participant who is injured by a third party. What they require in return is that the beneficiary reimburse them for those costs out of any tort recovery from that third party. The question in this case is whether a beneficiary can shirk that obligation by spending the tort recovery on consumable or intangible goods or services before the plan brings a legal action to enforce its undisputed right to reimbursement.

Respondent has ably explained why ERISA allows an equitable lien by agreement to be enforced even where the promisor has dissipated the funds subject to the lien. See Resp. Br. 25-46. This brief explains in further detail why a contrary rule would undermine the financial health of these plans and be fundamentally inconsistent with the equitable nature of Section 502(a)(3) of ERISA. Plans recover over $1 billion from reimbursement every year. That important funding stream will be threatened if beneficiaries could so easily avoid surrendering a double recovery to the plan. Even with rigorous and costly enforcement efforts, plans will not be able to keep up with the speed at which beneficiaries can secure and spend their tort recoveries. Each time a plan loses that race, more dollars will flow out of the plan and into the hands of a double-recovering beneficiary. To make matters worse, the expenses of these enforcement efforts will further erode a plan's financial ability to provide the same level of benefits without increasing the required contributions.

Crippling plans' ability to recover reimbursements will harm the participants themselves the most. They are the ones who will pay the increased premiums or make do with the reduced benefits required to bridge that billion-dollar shortfall. Thus, the loophole Petitioner seeks would enrich the few on the backs of the many. A relatively small percentage of participants would use it to obtain double recoveries to which they *concededly* have no

legal claim, and their fellow participants will pay the price for those windfalls. A statute grounded in equity cannot tolerate that unjust result.

ARGUMENT

I. Health And Benefit Plans Are Not-For-Profit Entities That Exist Solely To Serve Their Participants

Health and benefit plans and related trust funds provide health and welfare benefits to their participants. That is their sole function, and there is no profit in it. These plans must amass assets to cover contingent liabilities and the costs of administration, but they do not produce any profit. Instead, the contributions, reimbursements, and other sources of revenue go towards funding the participants' benefits. Any excess is used to provide an insurance reserve to cover future contingencies (increased future health costs; decreased employer and employee contributions in times of unemployment; and fluctuations in market investments). Accordingly, plan participants have the greatest interest in the financial stability of the plans. They gain the most from a funding surplus, and they lose the most from a funding shortfall. Since there is no "deep pocket" insurance company or for-profit corporation behind the health fund (especially in the case of multiemployer funds, such as the one at issue in this case), a funding shortfall imperils participants' benefits and increases their costs. The bottom line is that these plans are created for workers (and often by workers), and anything that harms them harms the workers as well.

A. *Amicus* the Fund illustrates these basic facts. The Fund is the result of collective bargaining between the International Brotherhood of Electrical Workers union and the National Electrical Contractors Association contractors. Workers in the construction industry often work by the job and change employers frequently, mak-

ing it difficult to maintain health and welfare benefits. The Fund solves that problem by offering those benefits directly to the union participants who work in the industry rather than routing them through a particular employer.

Actuarial calculations estimate the cost of providing the benefits and yield a recommended contribution rate for employers and workers so that the Fund can remain solvent. The Fund's Board of Trustees (which is divided equally between representatives from management and labor) then sets the contribution rate based on that analysis.

The Fund makes no profit for the employers. Indeed, it is statutorily prohibited from doing so. The Fund is a Voluntary Employees Beneficiary Association under Internal Revenue Code Section 501(c)(9), which specifically prohibits any "part of the net earnings of such association inur[ing] * * * to the benefit of any private shareholder or individual." 26 U.S.C. § 501(c)(9). The only statutorily authorized distributions are those "for the payment of life, sick, accident, or other benefits to the members of such association or their dependents or designated beneficiaries." *Ibid.* Any excess funds that are not needed for that sole purpose remain in the Fund and create a surplus. The surplus provides a reserve against future costs, which in turn holds down premiums.

B. As the Fund's example demonstrates, workers depend on these plans and count on them being financially stable. That is why the plans place so much emphasis on cost projection, premium calibration, and obtaining reimbursement when possible. This last focus is particularly important because these plans are zero-sum games. Each extra dollar distributed to a plan participant is a dollar that cannot secure benefits for the other workers covered by the plan absent an added dollar in plan premiums.

Plans have developed detailed rules for payment and reimbursement of benefits to address that issue. As highlighted in this case, one common rule provides that the plan will pay benefits for a worker injured by a third party on the condition that the worker will reimburse the plan for those payments out of any tort recovery secured from the third party. See *Kress* v. *Food Emp'rs Labor Relations Ass'n*, 391 F.3d 563, 569 (4th Cir. 2004) ("Subrogation clauses requiring reimbursement are * * * quite common."). The purpose of that rule is not to enrich plan administrators or employers, but to ensure equitable distribution of plan funds to the participants. Indeed, plans do not charge workers interest on the large sums advanced for payment of medical expenses prior to recovery from a third party. All they ask is that the worker pay the plan back the principal if the responsible third party is ultimately called to account.

Workers who obtain a double recovery by avoiding their reimbursement obligations are, in effect, taking money out of the pockets of their fellow participants. That is why plans need the most effective tools possible to enforce these reimbursement provisions that safeguard the financial health of the plan and prevent the inequitable distribution of plan funds.

II. Impediments To Reimbursement Impose Real Costs That The Plan Participants Must Bear

Allowing beneficiaries to avoid their undisputed reimbursement obligations imposes steep costs on plans, costs that ultimately fall on the plan participants. Reimbursements from tort recoveries constitute a substantial funding stream for plans. Petitioner's own *amicus* The American Association for Justice ("AAJ") cites a study concluding that such reimbursements return "in excess of $1 billion" to plans every year. AAJ Br. 20 n.2 (citing Baron & Lamb, *The Revictimization of Personal Injury Victims by ERISA Subrogation Claims*, 45 Creighton L.

Rev. 325, 325 (2012)).[2] Each impediment to enforcing those reimbursement rights results in more of that money remaining an inequitable windfall to a few beneficiaries that cannot be returned to the plans to work for the benefit of all participants.

A. The sheer size of that $1 billion-plus figure speaks for itself. It represents a staggering amount of doctor visits, medications, surgeries, and other needed benefits for participants.

Amicus AAJ attempts to downplay the enormity of this $1 billion funding stream by dividing it by the 137 million people covered by these plans. The result, it argues, is that Petitioner's rule may only impose a "miniscule" cost of $5.84 per covered person per year. AAJ Br. 21. This per-person metric is misleading, because many of the 137 million covered persons are family members of a worker who gain coverage under a family health plan. Accordingly, that few dollars per person per year becomes tens of dollars per family, which can add up over time to many hundreds of dollars.

More fundamentally, however, AAJ's argument proves too much. Unwarranted windfalls to a select few can always be minimized by dividing them among a large group that bears the cost. But such math ignores the aggregate impact of these windfalls and the fact that organizations must work to hold down costs on numerous fronts. For example, the Treasury Inspector General for

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[2] See also Br. of *Amicus Curiae* America's Health Ins. Plans, Inc. *et al.* in Support of Respondent, *Sereboff* v. *Mid Atl. Med. Servs.*, 547 U.S. 356 (2006), 2006 WL 460877, at *3 n.3 (independently calculating reimbursement recoveries at over $1 billion per year); Healthcare Subrogation and Recovery, https://www.xerox.com/en-us/services/healthcare-payers/subrogation-recovery (last visited September 4, 2015) (noting that Xerox recovery services "has recovered over a billion dollars on behalf of our healthcare subrogation clients" in just the past three years).

Tax Administration ("TIGTA") has estimated that the IRS paid out $3.3 billion in refunds for fraudulent tax returns in 2013. See TIGTA, *Efforts Are Resulting in the Improved Identification of Fraudulent Tax Returns Involving Identity Theft* (April 24, 2015), https://www.treasury.gov/tigta/auditreports/2015reports/201540026fr.pdf. Yet this fraud obviously cannot be justified or minimized by dividing that number by the 318 million residents of the United States.

It is undisputed that participants in these cases have agreed and have a legal obligation to reimburse the plan with funds recovered from third parties. The attempts of some to escape that obligation and obtain a double recovery clearly cannot be justified under equity by the fact that this windfall will be financed by a large number of plan participants.

B. The minority view held by the Eighth and Ninth Circuits threatens to cut off, or at least substantially reduce, the sizeable funding stream represented by reimbursements. See *Treasurer, Trs. of Drury Indus., Inc. Health Care Plan & Trust* v. *Goding*, 692 F.3d 888, 897 (8th Cir. 2012); *Bilyeu* v. *Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083, 1095 (9th Cir. 2012). Only a few years have passed since those troubling decisions, and plan participants in those circuits may not yet be aware of their new route to double recovery created by these courts. The passage of time will change that, particularly if this Court enshrines that flawed approach as the law of the land. See *Timmons* v. *Twin Cities Area New Party*, 520 U.S. 351, 357, 364-365 (1997) (recognizing possible ill effects of permitting multi-party candidates despite the fact a few states allow such candidates); cf. *id.* at 375 n.3 (Ginsburg, J, dissenting).

Once participants learn that spending any tort recovery on consumable or intangible goods or services immunizes them from later claims of reimbursement from

the plans, the strategic choice for some participants will be to do just that. The participant will spend the recovery as quickly as possible on consumables and intangibles or risk losing it altogether when the plan comes around to collect its reimbursement.

The impact of this reduced funding will be borne by all participants, as they must reach into their own pockets to make up the difference in the form of higher contributions or reduced benefits. See *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 11 (1987) ("[I]nefficiencies in benefit program operation * * * might lead those employers with existing plans to reduce benefits * * * "); *Zurich Am. Ins. Co.* v. *O'Hara*, 604 F.3d 1232, 1238 (11th Cir. 2010) ("If O'Hara were relieved of his obligation to reimburse Zurich for the medical benefits it paid on his behalf, the cost of those benefits would be defrayed by other plan members and beneficiaries in the form of higher premium payments.").

C. AAJ attempts to obscure this fact, questioning the mechanism by which reduced reimbursement recovery could affect plan premiums. See AAJ Br. 15-21. But the mechanism is basic economics. Plans are not-for-profit entities, and actuarial standards demand taking reimbursement recoveries into account when recommending contribution levels: "The actuary should take into account the relevant organizational practices and regulatory requirements related to * * * subrogation. In particular, the actuary should consider how these items are reflected in the data (for example, negative claims or income) and make appropriate adjustments for * * * subrogation, or other adjustments or recoveries." Incurred Health and Disability Claims, Actuarial Standard of Practice No. 5, § 3.3.5 (Actuarial Standards Bd. 2011), http://www.actuarialstandardsboard.org/wp-content/uploads/2013/12/asop005_126.pdf. Thus, under actuarial practice, each dollar returned to the plan through reim-

bursement is one less dollar that must be raised through contributions paid by plan participants.

AAJ speculates that actuaries might not follow these standards and claims there is inadequate proof that reduced reimbursements in fact affect premiums. See AAJ Br. 17-18. Yet AAJ offers no explanation of why, in a not-for-profit entity, reduced costs would not, in the long run, be passed on to the ultimate consumer. See *ibid.* Instead, it simply offers the glib and unsupported claim that "[t]here are plenty of uses for found money." *Id.* at 17. That assertion ignores the not-for-profit nature of ERISA plans. These plans obtain funding from three sources: contributions, reimbursements, and investment income. A reduction in any of these three sources demands a corresponding increase in one of the other two funding streams or a reduction in expenses, *i.e.*, benefit payments. Therefore, the workers necessarily will pay for decreased reimbursements one way or another. Either premiums will rise to make up the shortfall, with the workers contributing to those premiums directly or indirectly, or the workers' benefits will be cut. There is no free lunch in these plans, and the workers who abide by the terms of the plans will be the ones who foot the bill for the few participants who fail to honor their reimbursement obligations.

III. The Right To Recover Against The Beneficiary For Dissipated Funds Is The Most Efficient And Effective Protection Against Double Recovery

A. There is only one surefire way to deter double recoveries and correct them when they do occur: authorizing a direct action against the offending beneficiary for the reimbursement owed. The mere existence of such a right will stop most of the reimbursement violations before they happen. It eliminates the incentive to dissipate tort recoveries that rightly belong to the plan. Partici-

pants will abide by the terms of the plan agreement if they know the plan can effectively enforce those terms against them.

In addition to deterrence, this direct approach also provides the plans a relatively inexpensive method of enforcing their reimbursement rights. Maintaining a constant state of readiness and the ability to pounce on tort recoveries before funds are dissipated is a costly proposition. But that will not be necessary if the plans can secure reimbursement directly from the offending beneficiaries even if they have already dissipated the recovery that rightly belongs to the plans. Under that regime, plans will be able to conduct a proper investigation of each claim before filing suit, rather than immediately filing suit whenever any reimbursement right may possibly exist. The result will be significant cost savings. This common-sense path achieves "ERISA's objective of efficient plan administration." *Egelhoff* v. *Egelhoff ex rel. Breiner*, 532 U.S. 141, 149 n.3 (2001).

B. Petitioner and his *amici* suggest a number of half-measures and circuitous routes to recovery as alternatives to this direct method. See Pet. Br. 44; AAJ Br. 24-25. But all of those fall woefully short of the benchmark set by the direct action against the wrongdoer for the amount of the reimbursement. Some of the suggested alternatives might offer the plans some relief, but at the cost of significant expenses that they would not otherwise incur. Filing suit against the tortfeasor directly is a perfect example. See AAJ Br. 24. A plan could take this route pursuant to its subrogation rights, but it would incur many legal expenses in the process. And those are in addition to the administrative expenses of managing what would be a massive litigation docket and investigating all the potential suits it might have to file. Intervening in a suit initiated by a participant is another option, but that too entails steep costs. See *id.* at 24-25. Inter-

vention also does nothing to ensure that plans secure reimbursement from tort suits settled before the initiation of litigation or before intervention is feasible.

As an alternative to full-fledged involvement in the underlying litigation, Petitioner points out that a plan could enjoin a participant from dissipating a tort recovery that rightfully belongs to the plan. See Pet. Br. 44. That is technically an option under 29 U.S.C. § 1132(a)(3), but it is almost impossible to execute effectively and consistently. As Respondent explains, courts have sometimes denied injunctive relief in these situations, and even when relief is forthcoming, it may not be timely enough to prevent dissipation. See Resp. Br. 51-52.

Additionally, the injunctive relief program envisioned by Petitioner is not a realistic option given the administrative realities of these plans. Plans often serve a large number of participants with a small administrative staff. Yet Petitioner expects them to both discover and then monitor in real time all of the litigation and out-of-court negotiations between their beneficiaries and tortfeasors. Not only that, but the plans also must be able to act at a moment's notice, seeking an injunction as soon as it learns of a participant's recovery. That is unrealistic. In a race between an individual beneficiary dissipating a tort recovery and a plan taking action to enjoin that dissipation, the beneficiary will win almost every time. Even if plans were capable of such nimbleness, the reimbursements likely would not be worth the astronomical costs of monitoring all of these potential tort recoveries and maintaining a constant state of readiness.

Take the Fund as an example. It provide benefits to over 15,000 people, and it does so quite efficiently, with a team of only 11 people overseeing that massive operation. The alternatives discussed above are not feasible with such a small administrative team. Adopting Petitioner's approach would require the Fund to overhaul its opera-

tions and significantly expand the size of the team running the Fund. Each additional employee hired would take more money away from providing benefits and reduce the efficiency of the Fund's operations.

C. The alternatives get worse from there. If the beneficiary uses the settlement funds to purchase an asset rather than a consumable or intangible good or service, then the plan can enforce its equitable lien against that asset. See Pet. Br. 44. And if the beneficiary gives the tort recovery to someone else, the plan can enforce its lien against that person. See *ibid.* But those are not solutions. They are acknowledgements that plans may have recourse in the unlikely event a beneficiary inexplicably fails to avail himself of the huge legal loophole Petitioner seeks to create. And, in any event, these measures would be more complicated and more costly than a direct suit against the dissipating beneficiary.

Straining credulity, Petitioner and AAJ promise that obtaining reimbursement will not be a problem because legal ethics rules require personal-injury attorneys to withhold the portion of the tort recovery subject to the plans' reimbursement rights. See Pet. Br. 42-43; AAJ Br. 25-26. The real-world result is not as Petitioner and AAJ claim. Where such ethics rules exist, they often place the plaintiff's attorney's interest in recovering his contingent fee in direct conflict with the plan's reimbursement right. Here, for example, the plan requires full reimbursement of tort recoveries, "without reduction for attorneys' fees." Resp. Br. 5 (quoting J.A. 46). Thus, where the plaintiff's attorney facilitates reimbursement, he is often working again his own interest—a dollar reimbursed to the plan is a dollar not recovered by the contingency-fee attorney.

The best evidence of this continuing reimbursement problem despite whatever ethics rules may exist is this case and the multitude of other cases that eventually re-

sulted in the circuit split on this very issue. These cases arose only because a beneficiary obtained the tort recovery and dissipated it before the plan could claim its fair share. The reality is that legal ethics rules are not protecting plans' reimbursement rights.

D. In the final stop on its tour of implausible alternatives, AAJ recommends that plans "compromise" with the participant over the amount of reimbursement. See AAJ Br. 25. In other words, plans should recognize their weakened legal position in light of Petitioner's loophole and look the other way as long as the double recovery is not too egregious. Even if that were a solution, it is unclear why a participant armed with a right to dissipate would bring his case to the plan's attention and then make an attractive settlement offer. But putting that aside, the best-case scenario still leaves plans with a greatly reduced reimbursement funding stream.

All of these suggested alternatives "undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Egelhoff*, 532 U.S. at 149-150 (quoting *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990)). None of them can hold a candle to the common-sense approach of allowing plans to seek reimbursement from the person denying them that right—the dissipating beneficiary. That direct method offers the only efficient and effective way to enforce the plans' critical reimbursement rights.

IV. Equity Disfavors A Beneficiary's Unlawful Dissipation

At bottom, the issue in this case is whether the relief the Respondent seeks is "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3). Respondent has ably explained why the relief sought here qualifies as equitable under this Court's precedents and the historical understanding of that term. See Resp. Br. 25-46.

But the more basic point is that a statutory provision grounded in equity should not be read to allow a beneficiary to retain his ill-gotten double recovery. Petitioner's attempt to do so flies in the face of the most fundamental equitable principles. "[A] court of equity [w]as a vehicle for affirmatively enforcing the requirements of conscience and good faith." *Precision Instrument Mfg. Co.* v. *Auto. Maint. Mach. Co.*, 324 U.S. 806, 814 (1945). Yet Petitioner uses equity as a shield to avoid those very requirements, claiming that equity cannot reach the funds that rightfully belong to the plan once he has converted them to consumable or intangible goods or services. See Pet. Br. 23-36. Equity does not reward wrongdoers: "He that hath committed iniquity shall not have equity." *Milwaukee & M.R. Co.* v. *Soutter*, 80 U.S. 517, 523-524 (1871). Nor does it create loopholes: "[C]ourts of equity are loath to allow loopholes, technicalities, or gameplaying to dictate results when those results would violate basic notions of equity and fair play." *Coral Springs St. Sys., Inc.* v. *City of Sunrise*, 371 F.3d 1320, 1340 (11th Cir. 2004). Equity thus offers no aid to a dissipating beneficiary like Petitioner, for he is a wrongdoer in search of a loophole to avoid honoring his reimbursement obligation to his plan and, by extension, to his fellow plan participants.

CONCLUSION

For these reasons, the judgment of the court of appeals should be affirmed.

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No. 14-723

IN THE

Supreme Court of the United States

ROBERT MONTANILE,

Petitioner,

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF OF THE NATIONAL ASSOCIATION OF SUBROGATION PROFESSIONALS AND THE SELF-INSURANCE INSTITUTE OF AMERICA, INC. AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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INTEREST OF AMICI CURIAE[1]

National Association of Subrogation Professionals ("**NASP**"). NASP is a non-profit trade association of insurance companies, third-party administrators, subrogation specialists, and attorneys practicing in the field of subrogation and recovery. NASP has approximately 2,300 members, representing more than 425 insurance companies and self-funded entities (including employers and groups of employees). NASP's mission is to create a national forum for education, training, networking, advocacy, sharing of information, and, ultimately, the most effective pursuit of subrogation on an industry-wide basis.

Through NASP, members are able to retrieve, organize, and exchange information, as well as expand the use of technology to promote subrogation efforts on a cost-effective basis. The members of NASP recover billions of dollars annually, including hundreds of millions of dollars in health care expenditures every year for insured and self-funded employee benefit plans through subrogation and recovery practices. One of NASP's goals is to be the "voice of subrogation" for the public, government, and other organizations.

Because the members of NASP recover hundreds of millions of dollars in health care expenditures every year for insured and self-funded employee benefit plans, NASP

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1. No counsel for a party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than the *amici curiae*, or their counsel, made a monetary contribution to its preparation or submission. The parties have consented to the filing of this brief.

has an interest in whether the Employee Retirement Income Security Act ("ERISA") permits parties who have agreed to use funds recovered from responsible parties to reimburse health plans for medical expenses advanced on their behalf to nonetheless avoid that promise through dissipation. The Court's decision will have a profound impact on employee benefit plans' financial stability, which in turn will have far-reaching implications for the nation's health care system.

Self-Insurance Institute of America, Inc. ("SIIA"). SIIA is a non-profit organization with nearly 1,000 members, serving tens of millions of health plan beneficiaries, dedicated to the advancement and protection of the self-insurance industry. SIIA's membership includes self-insured entities such as employer plan sponsors, as well as service providers such as third-party administrators, reinsurance companies, and other entities that support the self-insurance business. SIIA is the only organization in the United States that exclusively represents firms, professionals, and organizations that participate in the broad spectrum of self-insurance, including self-insured group health plans.

Through SIIA, its members coordinate their views and provide practical information and recommendations to government and the public at large on a range of subjects relevant to the effective functioning of the self-insurance system, including the provisions of ERISA that concern self-insured health plans and plan participants. SIIA's mission includes rendering assistance to courts in their deliberations on significant self-insured health plan issues of broad concern to its members.

Collectively, SIIA and NASP have a strong interest in preserving their members' ability to recover plan funds from participants that accept medical benefits but then refuse to honor the reimbursement terms of their agreements after obtaining compensation for medical expenses through legal action against or settlement with persons not covered by the plan. *Amici*'s members depend on reimbursement to ensure solvency of their plans and to provide benefits to all participants at lower costs. To the extent that *Amici*'s members are barred from seeking reimbursement according to the terms of the plan, they might be forced to take dramatic action, such as increasing required plan contributions by covered employees (the equivalent of insurance premiums), reducing benefits, or otherwise amending plan terms to protect against this growing and unnecessary risk. Each of these scenarios would have the unfortunate result of reducing the availability of health insurance for the nation's workforce.

SUMMARY OF THE ARGUMENT

Employer-sponsored health plans offered pursuant to ERISA typically require beneficiaries (whose medical expenses are paid by the health plan) to reimburse the plan for that expenditure if the beneficiary later recovers a judgment or legal settlement from a responsible person (such as the driver at fault in a traffic accident). These reimbursement provisions provide a valuable source of cost recovery to the plan. The savings realized from reimbursement obligations help keep premiums and other plan costs lower, to the benefit of all participants. And they are eminently fair, as they seek only to recoup payments already made on behalf of the covered participant, and only from funds, benefits, or proceeds that the participant

receives from a party not covered by or administering the plan, and which arise from a tort or insurance claim.[2]

The Petitioner in this case, Robert Montanile, asks this Court to upend this established and important cost-containment practice and instead interpret ERISA's remedies provision, 29 U.S.C. § 1132(a), to prohibit actions for reimbursement when the beneficiary has spent the settlement funds he received—notwithstanding the Plan's existing equitable lien by agreement. Montanile contends that a beneficiary's dissipation of the fund cuts off the ability of a plan to obtain "appropriate equitable relief" under ERISA—even when the beneficiary was fully aware of the plan's requirement of reimbursement at the time he sought and accepted benefits from the plan, and even when the dissipation occurred after the beneficiary was aware of the plan's specific interest in a particular settlement. Under Montanile's desired ruling, participants would be encouraged—even incentivized—to knowingly and willfully spend settlement funds quickly to prevent the plan from recovering on its lien.

This Court should reject this argument and affirm the sound decision of the Eleventh Circuit below. The text and goals of ERISA, and the legal principles established by this Court's prior jurisprudence, make clear that a plan reimbursement provision gives rise to an enforceable

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2. There are other sources of funds that also may be subject to reimbursement provisions, such as a plan beneficiary's other insurance policies. Regardless of the source of these funds, it is important to ensure the enforceability of plan reimbursement and subrogation provisions, and to discourage beneficiaries from avoiding their obligations under the plan by dissipating funds they have promised to repay.

equitable lien on any funds issued by the plan due to the occurrence of a particular event and thereafter recovered by a beneficiary arising from the same event. Any other holding would contradict the language and the logic of the ERISA statutory scheme and this Court's precedents. And the financial consequences for plans—and the other beneficiaries of them—would be swift and severe.

To begin, this Court must recognize that the primary purpose of ERISA's civil remedies provision, section 502(a)(3), is to *enforce* plan terms. As this Court has recognized, the plan is "at the center of ERISA," *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1548 (2013). This Court's reading of the statute must be consistent with the statute's broader purpose of encouraging "a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

Moreover, this Court already has held that a reimbursement provision like the one at issue here gives rise to an equitable remedy, and thus falls squarely within section 502(a)(3)'s provision of "appropriate equitable relief." *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356, 361-63 (2006). Under *Sereboff*, once the beneficiary obtains control over the settlement funds, an equitable lien by agreement attaches and "no tracing requirement ... applies[.]" *Id.* at 365. The decision in *Sereboff* controls the outcome here.

Montanile and his *amici* rely extensively on *Great-West Life & Annuity Ins. Co. v. Knudson*, in which this Court held that no equitable lien attaches when a

beneficiary *never* acquires possession over a settlement fund. 534 U.S. 204, 214 (2002). But that is not the case here; Montanile concedes that he gained control over the settlement fund, and that he already had agreed to repay the Plan from that fund. *Sereboff* makes clear that tracing rules that applied to claims for restitutionary liens do not apply to equitable liens by agreement, and that Montanile's dissipation of the settlement fund cannot be used to avoid the Plan's equitable lien by agreement.

A contrary construction of ERISA's remedies provision would have disastrous consequences for plans. The right to recover costs through reimbursement and subrogation are critically important to ensuring the solvency of plans. This is particularly so for the large segment of plans that are self-insured and for which the recovery of every dollar directly benefits all other participants in the plan. Self-insured plans already represent a majority of participants covered through large employer-sponsored plans. This segment of the market is expected to increase with the ongoing implementation of health care reform.

If this Court were to deprive plans of the ability to recoup costs from dissipating beneficiaries by accepting Montanile's reading of section 502(a)(3), there would be no other effective way for plans to protect their right to reimbursement for costs advanced to beneficiaries. To begin, there is no way for plans to ensure that they receive notice of pre-litigation settlements, for which no public records exist. For those cases that do end up in court, monitoring the thousands of potential jurisdictions where a beneficiary may file a tort claim would be prohibitively expensive. Ultimately, with the ever-increasing rush of

jurisdictions looking to limit the rights of benefit plans to recoup funds, there is no guarantee that a plan could intervene in any state court tort action and thus be assured of direct participation in settlement negotiations.

Plans asserting a subrogation claim directly against the alleged tortfeasor may face an additional hurdle in a number of states that have prohibited insurers from seeking subrogation of any medical expenses. New York, for example, has made repeated attempts through its legislature to avoid ERISA's preemption scheme and create hurdles to recovery for insured and employer sponsored benefits plans alike. These same efforts have seemingly leached into the Second Circuit. *See Wurtz v. Rawlings Co., LLC*, 761 F.3d 232 (2d Cir. 2014), *cert. denied*, 135 S. Ct. 1400 (Feb. 23, 2015) (holding that ERISA did not pre-empt enforcement of New York state statute prohibiting subrogation actions). Nor do the professional rules governing attorneys' obligations to the creditors of clients provide any effective protection, as those rules contain numerous caveats and differ substantially among jurisdictions. And all of these alternative enforcement mechanisms highlighted by Montanile and his *amici* run counter to the organizing principle of ERISA: "to provide a *uniform* regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (emphasis added).

Montanile also suggests that plans can protect themselves by seeking a protective injunction in federal court, but this is not an effective or practical option in most cases. It would do nothing in the substantial number of cases where plans cannot ensure they receive notice of pre-litigation settlements. And even when plan administrators

learned of a potential settlement fund, they would face substantial legal and evidentiary obstacles to obtaining a federal injunction that would effectively prevent the dissipation of settlement funds. Moreover, requiring plan administrators (who have fiduciary obligations to the plan) to seek a protective injunction in every case would overwhelm the federal judiciary and drive up plan costs.

Because reimbursement and subrogation remedies are important to plans' solvency, if there is no effective way to enforce a beneficiary's reimbursement obligation, plans will have to make other adjustments to protect themselves and the majority of participants who have not dissipated funds from which they promised to repay medical expenses. Plans may raise required contributions or premiums to account for the increased financial risk that arises from dissipation. They may limit or cease advances to participants, waiting to pay medical bills until any alternative source has been definitively identified and held responsible. Or they may entirely exclude coverage for traffic accidents or other sources of large claims, which would force participants to purchase additional insurance coverage on the open market. All of these proposals would harm plan participants and disrupt a federal scheme for employer-sponsored benefit plans that has been remarkably effective to date.

In sum, there are no legitimate legal or policy reasons supporting Montanile's effort to secure a right to dissipation that overcomes his agreement to reimburse the plan for payments advanced on his behalf. Holding otherwise would contravene the logic of *Sereboff* and Congress's unmistakable intent to ensure an enforcement scheme that is uniform, cost-effective, and predictable.

This Court should affirm the decision of the Eleventh Circuit.

ARGUMENT

I. ERISA Requires The Enforcement Of Plan Terms, And Should Not Be Read To Allow Beneficiaries To Avoid Reimbursement Obligations Through Dissipation.

Montanile's attempt to undermine the enforceability of plan terms strikes at the heart of ERISA. It is inconsistent with the statute's text and its broader purpose of encouraging the creation of employer-sponsored benefit plans and providing uniformity and predictability as to the enforcement of the terms of those plans. It also runs afoul of prior decisions of this Court, which already have held that a plan's reimbursement provision creates an equitable lien by agreement that attaches to a subsequent settlement as soon as it comes into the possession of the beneficiary. This Court should adhere to the statutory framework and its prior decisions and reject Montanile's attempt to create a loophole to plan enforcement that would frustrate a plan's right to reimbursement.

A. Requiring A Beneficiary To Comply With His Or Her Reimbursement Obligation Advances Congress's Goal Of Ensuring The Enforcement Of Plan Terms.

This case turns on the meaning of section 502(a)(3) of ERISA, which permits "a participant, beneficiary, or fiduciary" to seek "appropriate equitable relief ... to enforce any provisions of this subchapter *or the terms*

of the plan." 29 U.S.C. § 1132(a)(3) (emphasis added). That is precisely what the Plan seeks here: enforcement of Montanile's agreement to reimburse the plan for expenses it advanced to pay for his medical care. Allowing a beneficiary to ignore this express promise and instead convert or dissipate the portion of the settlement that he agreed to repay would frustrate, rather than enforce, the terms of the Plan. Because section 502(a)(3) reflects Congress's intent to strengthen—rather than weaken—the enforceability of plan terms, this Court should affirm the decision below.

ERISA is a "'comprehensive and reticulated statute,' the product of a decade of congressional study of the Nation's private employee benefit system." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993) (quoting *Nachman Corp. v. Pension Benefit Guaranty Corporation*, 446 U.S. 359, 361 (1980)). The written plan is at the heart of this "interlocking, interrelated, and interdependent remedial scheme." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985). This Court has repeatedly observed that ERISA "is built around reliance on the face of written plan documents." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995); *see also US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1548 (2013). ERISA expressly requires "[e]very employee benefit plan" to "be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). The plan's administrator must in turn act "in accordance with the documents and instruments governing the plan[.]" *Id.* § 1104(a)(1)(D). "The plan, in short, is at the center of ERISA." *McCutchen*, 133 S. Ct. at 1548.

Given the statute's "repeatedly emphasized purpose to protect contractually defined benefits," *Russell*, 473 U.S. at 148, it is unsurprising that Congress provided remedies through ERISA that would serve to advance the terms of the plan, not defeat them. Section 502(a)(3) "does not, after all, authorize 'appropriate equitable relief' at large[.]" *McCutchen*, 133 S. Ct. at 1548 (quotations omitted). "[R]ather, it countenances only such relief as will enforce '*the terms of the plan*' or the statute." *Id.* (emphasis in original). *See also Mertens*, 508 U.S. at 253 (noting that section 502(a)(3) authorizes "'appropriate equitable relief' for the purpose of 'redress[ing any] violations or ... enforc[ing] any provisions' of ERISA or an ERISA plan.").

That is all that Respondent is seeking here: enforcement of the reimbursement provision in the Plan. Montanile no longer disputes that he agreed to reimburse the Plan for medical expenses it paid on his behalf from any settlement or judgment he later obtained. Petitioner's Brief ("Pet. Br.") at 11 & n.4. In reliance on this promise, the Plan advanced more than $121,000 to pay Montanile's medical expenses. Pet. Br. at 2. Montanile later obtained possession of a settlement that included funds from a party alleged to have been responsible for his injuries. *Id.* But despite his knowledge of his reimbursement obligation and the Plan's assertion of a claim to a portion of the resulting proceeds, Montanile failed to reimburse the plan. He now contends that by spending all the money, he is freed from his reimbursement promise, and the Plan is without any recourse. *Id.*

Permitting such easy avoidance of plan terms would undermine not only the express terms of section 502(a)(3),

but also the broader statutory goal of encouraging "a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp.*, 516 U.S. at 497. In other contexts, this Court has "recognized the particular importance of enforcing plan terms as written," *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604, 612 (2013), and this principle should apply with no less force here. The text of section 502(a)(3) and this Court's prior interpretations of ERISA's remedial provisions strongly weigh in favor of the Plan's attempt to enforce the reimbursement provision, rather than Montanile's blatant effort to avoid it.

B. *Sereboff* Held That ERISA Permits A Plan's Action For Reimbursement From A Particular Fund Without The Need To Satisfy Any Strict Tracing Rules.

To be sure, section 502(a)(3) permits "appropriate *equitable* relief" to enforce a plan's terms. 29 U.S.C. § 1132(a)(3) (emphasis added). Plans therefore may not enforce a particular term by bringing a claim for purely legal relief—that is, "the imposition of personal liability for the benefits that [a plan] conferred upon respondents." *Knudson*, 534 U.S. at 214. In *Sereboff*, however, this Court squarely held that reimbursement provisions like the one at issue here give rise to an equitable lien by agreement, which attaches to a subsequent settlement once the beneficiary obtains possession of the settlement funds. 547 U.S. at 362-63. And *Sereboff* further held that once the lien attaches, "no tracing requirement ... applies to equitable liens by agreement or assignment[.]" *Id.* at 365.

That rule decides this case. An equitable lien by agreement in favor of the Plan attached to the settlement fund as soon as it came into Montanile's control. Under *Sereboff*, it is of no consequence that, after receiving the dedicated settlement, Montanile ignored his reimbursement obligation and spent that money. Because the Plan's claim is consistent with section 502(a)(3)'s text, traditional principles that apply to equitable liens by agreement, and the broader statutory goal of ensuring enforcement of the plan's terms, this Court should affirm the Eleventh Circuit's decision.

Sereboff involved a plan—like the one at issue here—that required, among other things, a beneficiary receiving benefits under the plan to reimburse the plan for those benefits from any settlement or other recovery from a responsible party. *Compare* 547 U.S. at 359, *with* Pet. App. 5-7. As in this case, the beneficiary in *Sereboff* was injured, and thus received benefits toward medical care from the plan. 547 U.S. at 360. And, as here, the beneficiary later settled litigation with the person alleged to have been responsible for the injuries. *Id.* Most importantly, in both cases the beneficiary exercised control of a single settlement fund. *Compare id. with* Pet. App. at 12.

Once that occurred, this Court held, the equitable lien by agreement attached to those proceeds. *Sereboff* relied upon *Barnes v. Alexander*, 232 U.S. 117, 121 (1914), which applied "the familiar rul[e] of equity that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing." *Sereboff*, 547 U.S. at 363-64. The Court found that the plan covering the Sereboffs "specifically identified a particular fund, distinct from the Sereboffs' general

assets—'[a]ll recoveries from a third party (whether by lawsuit, settlement, or otherwise)'—and a particular share of that fund to which Mid Atlantic was entitled—'that portion of the total recovery which is due [Mid Atlantic] for benefits paid.'" *Id.* at 364. The plan could therefore "'follow' a portion of the recovery 'into the [Sereboffs'] hands' 'as soon as [the settlement fund] was identified,' and impose on that portion a constructive trust or equitable lien." *Id.*

The same is true here. An equitable lien by agreement attached to Montanile's settlement fund when that money—distinct from his other assets—came into his control. The fact that he exchanged or dissipated the funds thereafter is irrelevant, in light of *Sereboff*'s holding that "no tracing requirement ... applies to equitable liens by agreement." *Id.* at 365. "[A]ll that matters is that the beneficiary did, at some point, have possession and control of the specific portion of the particular fund sought by the insurer." *Thurber v. Aetna Life Ins. Co.*, 712 F.3d 654, 664 (2d Cir. 2013).

And, as Respondent explains in detail, *see* Respondent's Brief ("Resp. Br.") at 25-46, this rule is in conformity with the general principles of equity and the established practice in the days of the divided bench. *See, e.g.*, 2 Joseph Story, *Commentaries on Equity Jurisprudence as Administered in England & America* § 798 (Isaac F. Redfield ed. 10th ed. 1870) (discussing substitutionary monetary decrees when assets at issue were transferred without notice to bona fide purchaser); Fed. Equity R. 10 (1912) (permitting deficiency judgments for any shortfall upon sale of the property in question). And equity courts of the past would not permit an equitable lien by agreement to be easily discharged by simply spending down the fund

with full knowledge of the lienor's claim; such a result is antithetical to equity, which "eschews mechanical rules" and "depends on flexibility." *Holmberg v. Armbrecht*, 327 U.S. 392, 396 (1946) (Frankfurter, J.).

Nothing in this straightforward application of principles from *Sereboff* contradicts the decision in *Knudson*. In *Knudson*, the plan was pursuing a claim of equitable restitution—not an equitable lien by agreement. For restitutionary claims, the court held, it was necessary to trace the claim to particular funds in the defendant's possession. It thus was decisive that the beneficiary in *Knudson never* came into possession or control of the particular fund of settlement agreement. Under those circumstances, no equitable restitution claim against the beneficiary could be traced to those funds, and the action was indistinguishable from an attempt "to impose personal liability ... for a contractual obligation to pay money." *Knudson*, 534 U.S. at 210. It is thus incorrect to assume—as both the United States and Montanile do—that *Knudson* "endorsed ... restitutionary tracing rules ... to every action for an equitable lien under § 502(a)(3)." *Sereboff*, 547 U.S. at 365. To the contrary, *Sereboff* left no doubt that "no tracing requirement ... applies to equitable liens by agreement." *Id.* at 365.

Knudson remains good law with respect to claims for equitable restitution seeking funds that never come into the control of a beneficiary who agreed to reimburse a plan. But *Sereboff* teaches that a beneficiary who has granted a plan an equitable lien by agreement may recover on its lien from the beneficiary without any need to trace its ultimate recovery to the actual funds turned over to the beneficiary. This Court should hold fast to the principles set forth in *Sereboff*, and affirm the decision below.

II. Permitting Beneficiaries To Avoid Reimbursement Obligations Would Have Drastic And Detrimental Effects On Plans And Their Participants

Adopting Montanile's misguided interpretation of section 502(a)(3)[3] would directly threaten the financial stability of thousands of employer-sponsored health plans. The elimination of effective reimbursement remedies will inevitably increase those plans' annual costs by millions of dollars. These losses cannot easily be recouped or offset through other methods of reimbursement or subrogation.

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3. Contrary to the suggestion of the Petitioner, *see* Pet. Br. at 19-20, section 502(a)(3) of ERISA is not the only statutory provision that imposes liability on plan participants who wrongfully retain or dissipate plan funds. Anybody who acts as a fiduciary over plan assets is personally liable for resulting damages, and the plan may obtain all appropriate relief—not just equitable relief—to enforce that liability. *See* 29 U.S.C. §§ 1109, 1132(a)(2). ERISA's provisions of fiduciary liability includes a "participant" who exercises "control over assets" of a plan, 29 U.S.C. § 1104(C)(1)(A), and a number of courts have applied the statutory language and concluded that beneficiaries who wrongfully retain or dissipate assets they know are not theirs qualify as fiduciaries, and thus are properly liable under § 1132(a)(2). *See, e.g., West Virginia Laborers Pension Trust Fund v. Burkhammer*, No. 2:10-cv-01120, 2013 WL 3754822, at *2 (S.D. W. Va. July 15, 2013) (holding that a "person who wrongly retains benefit payments" is liable as a fiduciary under section 502(a)(2) and entering default judgment against beneficiary); *Int'l Painters and Allied Trades Indus. Pension Fund v. Aragones*, 643 F. Supp. 2d 1329, 1336-37 (M.D. Fla. 2008) (same); *Carpenters Pension and Annuity Plan v. Grosso*, No. 07-5013, 2009 WL 2431340, at *5-6 (E.D. Pa. Aug. 6, 2009) (same). While this route to relief does not alter the sound legal and policy reasons for permitting the enforcement of plan reimbursement provisions pursuant to section 502(a)(3) as an equitable lien by agreement, any decision by this Court should leave open this alternate form of liability.

Instead, they will require substantial adjustments to plan practices that currently benefit participants. This Court should not impose restrictions on ERISA's remedies that inevitably will harm plans and their participants.

A. The Enforceability Of Reimbursement Provisions Is Important To Plans' Solvency.

Subrogation and reimbursement are important mechanisms for preserving plan assets. In an era of rising health care expenses, cost containment measures are essential to keep benefits affordable. The elimination or reduction of recoveries from settlements or judgments would make health coverage, which is already difficult for many Americans to afford, even more expensive. One state has estimated that health insurance premiums for state workers would rise between 1% and 2% if insurers' ability to enforce subrogation and reimbursement provisions were eliminated.[4]

The importance of reimbursement and subrogation is a matter of basic economics. "Funds recovered through subrogation serve as a source of revenue" for plans or their insurers, and this revenue is taken into account when calculating the historical cost to determine "the basis of future actuarial rate setting" or required contributions. J. Thomas Allen, *ERISA Subrogation and Reimbursement Claims: A Vote to Reject Federal Common Law Adoption*

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4. *See* Department of Legislative Services, Maryland General Assembly, Senate Bill 903: Contracts Between Health Maintenance Organizations and Subscribers or Groups of Subscribers – Subrogation Provisions (2000), *available at* http://mlis.state.md.us/2000rs/fnotes/bil_0003/sb0903.PDF (last accessed Oct. 1, 2015).

of A Default "Make Whole" Rule, 41 Ariz. St. L.J. 223, 240 (2009). As an example:

> [S]uppose an insurance plan covers 100 people and during the first year the plan pays a total of $20,000 in damage claims. Based on that year, the calculation for the cost of insurance the following year will be $200 per person in order to cover the entire risk (assuming that, in the following year, the trend will stay the same and $20,000 in damage claims will be paid). Now suppose that the insurance company is able to subrogate and recover $5,000 of the $20,000 it paid that first year. The cost per person will now be $150, because of the increased revenue brought in through subrogation.

Id; *see also* Jeffrey A. Freenblatt, *Insurance and Subrogation: Where the Pie Isn't Big Enough, Who Eats Last?* 64 U. Chi. L. Rev. 1337, 1355 (1997) ("An insurance company sets its rates based on historical net costs," and when subrogation or reimbursement lower those costs, the corresponding savings will affect the resulting actuarial premium.). "Without subrogation, a part of the risk is shifted back to the insured, [who] pays more for the insurance because he retains ... a right to obtain through litigation a recovery that may actually exceed the actual loss that (after receiving insurance proceeds) he suffered." *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1297 (7th Cir. 1993) (Posner, J.).[5]

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5. Indeed, the federal government itself recognizes the economic importance of this cost-recovery mechanism, imposing similar obligations upon recipients of medical benefits through

Subrogation and reimbursement provisions are particularly important for self-funded employee welfare plans sponsored by employers and unions. Allowing these plans to recover paid medical expenses that are the financial responsibility of third parties permits them to eliminate duplicative payments to beneficiaries and preserve limited benefit dollars for the benefit of all participants. This permits employers to offer enhanced benefits to covered participants. For self-funded plans, there is no question that subrogation and reimbursement recoveries "inure[] to the benefit of all participants and beneficiaries by reducing the total cost of the plan." *Zurich American Ins. Co. v. O'Hara*, 604 F.3d 1232, 1238 (11th Cir. 2010) (enforcing reimbursement provision over participant's argument that recovery did not make participant whole).

Some of Montanile's *amici* minimize the importance of self-funded plans, citing nearly 10-year-old court filings to suggest that self-insured plans are an insignificant piece of the market. *See* Amicus Curiae Brief for American Association for Justice in Support of Petitioner ("AAJ Br.") at 17. This grossly understates the continued growth of self-insured plans, which cover a majority of employer-sponsored plans. This growth is likely to continue as the Patient Protection and Affordable Care Act ("ACA") continues to reshape the health insurance market.

Medicare. *See* 42 U.S.C. § 1395y(b)(2); *Taransky v. Secretary of the U.S. Dept. of Health and Human Servs.*, 760 F.3d 307, 321-22 (3d Cir. 2014) (holding that the Medicare Secondary Payer Act "authorizes the Government to seek reimbursement from Taransky's settlement, as she has received funds from a primary plan under the statute that has a demonstrated responsibility for her medical expenses").

Companies choose to self-fund employee health benefit plans because they allow employers greater freedom to offer benefits tailored to their particular needs. Under ERISA, "employers have large leeway to design disability and other welfare plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). By offering self-insured plans, employers are able to exercise direct control over claim settlements, to take advantage of greater flexibility in the design and administration of health plans to meet specific employee needs, to better manage cash flows,[6] and to avoid onerous state insurance regulations.

This flexibility has increased the attractiveness of self-funded plans, particularly for large employers or groups of employers. A recent report submitted by the Department of Labor to Congress indicated that as of 2012 (the last year for which data was available), plans with some self-insurance component covered more than 58 million participants.[7] This number in fact *understates* the percentage of the workforce covered by self-insured plans, as it excludes all self-insured plans with fewer than 100 participants (i.e., most small businesses).[8] The same

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6. For example, self-funded plans gain the financial advantage of the time-value of their capital. Because medical claims are paid as submitted, company assets can be retained as working capital and invested. Thus, interest can be earned on funds that are retained by the employer and that otherwise would be paid in the form of premiums for conventional insurance.

7. Annual Report on Self-Insured Group Health Plans, at iv (March 2015), *available at* https://www.dol.gov/ebsa/pdf/ACAReportToCongress2015.pdf (last accessed Oct. 1, 2015).

8. *Id.* at ii.

report indicated ongoing growth in both the number of self-insured plans and the number of people covered by them.[9] Other analysis indicates similar growth: "[s]elf-insured plans provided insurance to 61 percent of all U.S. workers covered by an employer-sponsored health plan in 2011, up from 41 percent in 1998."[10] These numbers confirm employers' preference for self-insured plans as a cost-effective way to provide health insurance to employees and their dependents.

The increase in participant coverage by self-insured plans is likely to continue in the wake of the enactment of the ACA. One industry observer noted that "[e]mployers generally, and small employers particularly, are concerned about the rising cost of providing health coverage and may view self-insurance as a better way to control expected cost increases."[11] Self-insured plans also are exempt from some of the ACA's mandates, leading some employers to "view self-insurance as a way to avoid additional costs under the ACA" while retaining the ability to provide beneficial and affordable coverage to their employees.[12]

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9. *Id.* at iv.

10. Stephen Miller, *House Hearing Scrutinizes Self-Insured Plans: Federal regulators eye restrictions on stop-loss coverage* (Feb. 28, 2014), *available at* http://www.shrm.org/hrdisciplines/benefits/articles/pages/self-insured-plans-scrutinized.aspx (last accessed Oct. 1, 2015).

11. Stephen Miller, *More Employees Covered by Self-Insured Health Plans* (Dec. 3, 2012), *available at* http://www.shrm.org/hrdisciplines/benefits/articles/pages/self-insured-health-plans.aspx (last accessed Oct. 1, 2015).

12. Miller, *supra* n.10.

The ongoing growth in self-insured plans—which undoubtedly share the benefit of any reimbursement with all other plan participants—underscores the importance of retaining remedies that benefit all participants when they are able to enforce plan requirements for reimbursement and recover costs from settlements. Such recoveries are essential to "protect the solvency of employee benefit plans to ensure that the valid claims of employees and their beneficiaries will be paid." *McGann v. H & H Music Co.*, 742 F. Supp. 392, 393 (S.D. Tex. 1990) (citation omitted). These plans, and the participants they serve, should not be handcuffed by a cramped reading of section 502(a)(3)'s right to "appropriate equitable relief."

B. Plans Cannot Reliably Protect Their Right To Reimbursement Outside Of An Enforcement Action Under § 502(a)(3).

Some of Montanile's *amici* contend that plans retain adequate remedies to recover reimbursement even if ERISA's remedies are constrained so as not to permit an action to recover settlements that have been dissipated. For example, the American Association for Justice contends that a plan "can assert its right of subrogation and file its own action against the tortfeasor," or "intervene in the action filed by its beneficiary and participate in settlement negotiations to ensure its reimbursement rights are protected." AAJ Br. at 24-25; *see also* Amicus Curiae Brief of the United States in Support of Petitioner ("U.S. Br.") at 30-31. But these proposals are neither a realistic nor efficient substitution for simple enforcement of the plan's reimbursement terms. Indeed, the cost and complications of directly intervening in each case would likely be so substantial as to leave plans looking

at alternative protections that will damage beneficiaries' interests in the long run.

Consider first the suggestion that plans simply seek to timely intervene in any dispute between a fiduciary and a tortfeasor to protect their rights. To begin, "[i]t is common knowledge that a large percentage of the claims covered by insurance are settled without litigation and that this is one of the usual methods by which the insured receives protection." *Dairyland Ins. v. Herman*, 954 P.2d 56, 61 (N.M. 1997) (citation omitted); *see also Langdon v. Champion*, 752 P.2d 999, 1003 n.9 (Alaska 1988) ("[I]t is well known that only a small fraction of [automobile accident] claims involve litigation. The vast majority are settled without litigation and without lawyers.").

Several surveys have confirmed the prevalence of pre-litigation settlements. For example, a report from Washington State determined that lawsuits were filed only 47.3 percent of the time, but for claims without litigation, claimants were compensated 51.8 percent of the time. *See* 2014 Medical Malpractice Annual Report, Washington State Office of the Insurance Commissioner (Aug. 2014), http://www.insurance.wa.gov/about-oic/commissioner-reports/documents/2014-med-mal-annual-report.pdf; *see also* Marc A. Franklin et. al., *Accidents, Money, and the Law: A Study of the Economics of Personal Injury Litigation*, 61 Colum. L. Rev. 1, 10 (1961) (noting that of 193,000 accident victims with personal injury claims in New York annually, 39,000 proceed without counsel, and "[a]pproximately 116,000 are closed without suit"). This is especially likely to be true when the injuries and financial damages are serious and fault is not in doubt—not an uncommon occurrence in serious automobile accidents. In

such cases, a plan is dependent almost entirely upon the beneficiary to disclose the settlement process; there are not, and never will be, any court records to check or filings to monitor. Pre-litigation settlements may thus result in a transfer of funds that the plan has no easy way to timely discover, let alone intervene and participate in.

Even for those tort cases that do end up in court, establishing a process to monitor the thousands of jurisdictions where a tort claim may be filed is prohibitively expensive. For although claims under ERISA are subject to exclusive jurisdiction in federal court, those injured in automobile accidents, slip-and-falls, or other personal injury torts may sue alleged tortfeasors in state or federal court (provided the requirements of diversity jurisdiction are satisfied). Plans whose coverage extends nationwide may have tens of thousands of potential reimbursement claims a year. Each plan would have to implement "very careful monitoring of all beneficiaries, which may prove to be very costly [because each] plan would have to devise a way to flag claims that have the potential for tort litigation down the line." Randal M. Whitlatch, *Subrogation Under ERISA and the Search for "Appropriate Equitable Relief,"* 41 Tort Trial & Ins. Prac. L.J. 1049, 1075 (2006).[13]

Additionally, there is no guarantee that a plan will be permitted to intervene in a tort action, particularly if one is pending in state court. Plans face potential variations among local jurisdictions in the standards, deadlines, and

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13. Although plan terms often require a beneficiary to notify the plan of any potential third-party claim, a beneficiary intent on avoiding their reimbursement obligation is unlikely to comply with the notice requirement—and would have no incentive to do so if Montanile prevails in this Court.

procedures for intervention. And even when those varying requirements are met, there is still no assurance that state courts would permit a plan to intervene in a pending action. ERISA grants federal courts exclusive jurisdiction in almost all cases, including actions by a plan for relief against a beneficiary. *See* 29 U.S.C. § 1132(e)(1). Thus, "a plan may intervene only to have its case dismissed due to the complete preemption of ERISA." Whitlach, *supra*, at 1075. Although the plan could still file a separate action for enforcement against its beneficiary in federal court, its ability to participate directly in the state court action and secure a right against dissipation is very much in doubt—assuming state law does not prohibit exercise of that right in the first place. *See Wurtz*, 761 F.3d at 245 (holding that state law may prohibit enforcement of subrogation rights notwithstanding contrary terms of an ERISA plan).

The same issues of notice and cost apply equally to the argument that plans could protect themselves against dissipation by filing subrogation actions directly against tortfeasors. But this proposal comes with an additional significant hurdle, at least for insured plans: state anti-subrogation laws.[14] The United States implicitly acknowledges this restriction, noting (without further elaboration) that "plans may exercise that option *when subrogation is permitted under state law*." U.S. Br. at 30 (emphasis added). A number of states have anti-subrogation statutes specifically designed to prevent insurers from

14. Although ERISA generally preempts state laws that affect benefit plans subject to the statute, 11 U.S.C. § 1144(a), it excludes from preemption "any law of any State which regulates insurance, banking, or securities." *Id.* § 1144(b)(2)(A).

directly enforcing reimbursement provisions.[15] *See, e.g.*, C.G.S.A. § 52-225a; Kan. Admin. Regs. § 40-1-20; N.J.S.A. § 2A:15-97; 11 N.C.A.C. § 12.0319; Va. Stat. § 38.2-3405. These laws may prevent a plan from directly asserting a claim over any judgment or settlement in a case initiated by a beneficiary, again forcing it to seek relief through a parallel federal action that may ultimately be insufficient to prevent a beneficiary's dissipation of the actual dollars received in a litigation settlement.

Nor can plans rely on attorneys' professional obligations under state law to protect their right to reimbursement and the equitable lien created thereby. Such rules have no applicability whatsoever when a case is settled via insurance agents, where no attorney needs to get involved. *See supra* at 23-24. Even for those cases that reach litigation, states do not have uniform rules regarding an attorney's obligation to ignore client instructions to disburse funds subject to an agreed-upon lien. *See* Resp. Br. at 53-54. And even where *some* state's professional code *might* require an attorney to ignore her client's direction to disburse funds that are subject to a "*valid* assignment of rights to the proceeds of a settlement or [] a consensual lien on the settlement," *see* Virginia Legal Ethics Opinion 1747, *Attorney Breaching Contract to Pay Medical Bills Out of Settlement Proceeds* (emphasis added), there is little to stop a creative attorney from alleging that the plan's

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15. "Unlike subrogation, which arises under state law and allows the insurer to stand in the shoes of its insured, reimbursement is a contractual right governed by ERISA and comes into play only after a plan member has received personal injury compensation. While subrogation and reimbursement may have similar effects, they are distinct doctrines." *Unisys Medical Plan v. Timm*, 98 F.3d 971, 973 (7th Cir. 1996).

lien is somehow invalid or subject to a dispute, thereby taking them out of the letter of the rule. *See id*; *see also* Ga. R. Prof. Cond. 1.15(I)(b) (noting that "[t]he lawyer may disregard the third person's claimed interest if the lawyer reasonably concludes that there is a valid defense to such lien, judgment, or agreement").

This case illustrates the point: Montanile's attorney alleged that the Plan's reimbursement provision was unenforceable because it appeared only in the plan summary—a claim uniformly rejected by the courts below and which has since been abandoned. Pet. Br. at 11. But Montanile's attorney did not wait for resolution of that question by a court, or initiate an interpleader action to preserve the funds. It disbursed them as directed, resulting in their dissipation. *Id.* at 11-12. There is no evidence that professional discipline awaits—let alone that there is an available legal remedy against an attorney for improper disbursement that might make a plan whole.

Moreover, all of these suggestions that plans resort to various state laws to protect their interests ignore the overriding purpose of ERISA: "to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987); *see also Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) ("The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans."). "Uniformity is impossible however, if plans are subject to different legal obligations in different states .... Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal

of 'minimizing the administrative and financial burdens on plan administrators--burdens ultimately borne by the beneficiaries.'" *Egelhoff v. Egelhoff*, 532 U.S. 141, 149-150 (2001) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)). To address this concern, Congress gave plans a right to an exclusive federal forum to resolve disputes. 29 U.S.C. § 1132(e)(1). Removing that right and forcing ERISA plans to seek relief under the varying procedural and substantive restrictions available in the states is a recipe for the "administrative costs" and "litigation expenses" that "unduly discourage employers from offering plans in the first place." *Varity Corp.*, 516 U.S. at 497.

Montanile suggests that even without the ability to intervene or file an action for subrogation, a plan may seek and obtain an injunction in federal court. *See* Pet. Br. at 3, 22 n.13. But even assuming that a plan becomes aware of a potential settlement, as Respondent explains, there is no guarantee that it will be able to meet the strict standards for Article III standing or injunctive relief at that time. *See* Resp. Br. at 51-52 (citing *City of Los Angeles v. Lyons*, 461 U.S. 95, 102 (1983) and *Winter v. NRDC*, 555 U.S. 7, 24 (2008)). And if an administrator waits until a settlement is actually consummated, it may be too late to stop the beneficiary from evading the equitable lien and spending the funds. Moreover, reliance on protective injunctions invites a tidal wave of federal litigation, as ERISA fiduciaries may feel compelled to file for a protective injunction in every single case.

A final suggestion from Montanile's *amici* is particularly telling—they argue that plans should simply accept the fact that they are powerless to prevent dissipation, and

therefore they should "compromise with its beneficiary on a lower reimbursement, rather than litigate for the full amount, with the attendant risk of loss or inability to collect on a judgment." AAJ Br. at 25. This, of course, is not an alternative method to *enforcing* a reimbursement obligation; it is instead a capitulation to the party who is refusing to honor the agreement to reimburse. This "alternative" reveals the real goal of many supporters of Montanile in this case: to enact new substantive hurdles to plan enforcement that they were unsuccessful in obtaining from this Court in *McCutchen* and *Sereboff*.

C. If Plans Cannot Enforce Reimbursement Provisions, They Will Impose Offsetting Cost-Control Mechanisms That Will Be Detrimental To Plan Participants.

If this Court eliminates the ability of plans to enforce reimbursement provisions against beneficiaries who ignore the terms they agreed to and dissipate settlement funds, it ultimately will harm plan participants. Plan administrators have the ability and fiduciary obligation to impose alternative cost-control mechanisms. The predictable options all involve eliminating, or at least restricting, practices that currently benefit injured plan participants.

First, employers may be forced to reduce or eliminate certain benefits, increase premiums, or do both, because a plan's ability to obtain reimbursement from participants is a significant factor in establishing benefit levels and plan rates. If the plan's right to reimbursement is denied, the cost of paying for the underlying benefits falls to those who make the contributions that support plan benefits.

In the absence of a predictable right to recovery, plans will be forced to protect against the resulting risk by raising rates or decreasing benefits for all participants. Plan participants that honor their obligations under plan reimbursement provisions should not be forced to bear these costs.

Second, an erosion of reimbursement rights may force plan providers to adopt alternative approaches that shift greater burdens to plan participants. For example, plan providers faced with escalating costs could elect to defer or delay payment of claims for medical expenses related to another party's negligence until the accident liability issues have been fully resolved or until litigation has concluded. *See, e.g., Kress v. Food Empires Labor Relations Ass'n*, 391 F.3d 563, 568 (4th Cir. 2004) ("Since third-party accident and sickness benefits are not even covered by the Fund, nor required by ERISA, it makes little sense to argue that ERISA precludes imposing conditions on the receipt of benefits that are in effect an interest-free loan.").

Third, to secure the certainty of recovery of medical expenses if section 502(a)(3) remedies are weakened, plans could choose to offset future benefits. In other words, a plan could add language to an existing reimbursement provision permitting the fiduciary to deny future benefits equal to the amount of money that should have been reimbursed under the terms of the plan. Or more drastically, plan sponsors might be compelled to amend their plans to exclude coverage for medical expenses related to the negligence of other parties. Such restrictions are permissible because, as this Court has recognized, ERISA "does not regulate the substantive content of

welfare-benefit plans." *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 732 (1985), and nothing in federal law "requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content." *Ryan by Capria Ryan v. Federal Express Co.*, 78 F.3d 123, 127 (3d Cir. 1996). If plans were to eliminate this coverage, participants will ultimately have to pay retail rates for their medical expenses out of their own pockets because individuals cannot negotiate the more favorable group rates available to an employee benefit plan.

The net consequences of all of these possible outcomes would be higher plan costs and reduced plan benefits, harms that will be shifted to all plan participants, including plan participants that honor the terms of their agreements. This unnecessary and unwarranted shift of risk allocation would come at a time when employers are finding it increasingly difficult to provide benefits to their employees. "Cost of employer-sponsored coverage is the most common reason employers cite for not offering health coverage."[16] Indeed, premiums have more than doubled since 2001, and system-wide increases in health care costs going forward are expected to outpace the growth in national income for the foreseeable future—despite the enactment of the ACA.[17] The relief requested

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16. The Henry J. Kaiser Family Foundation, *The Uninsured: A Primer: Key Facts About Americans Without Health Insurance* (Jan. 2015), *available at* http://files.kff.org/attachment/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-america-primer (accessed on Oct. 1, 2015).

17. *See* The Henry J. Kaiser Family Foundation, *Health Care Costs, A Primer* at 2 (May 2012), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7670-03.pdf (accessed on Oct. 1, 2015).

by Montanile threatens to further increase costs, upend beneficial aspects of qualified plans for all participants, and provide a benefit only to those who seek to avoid abiding by disclosed plan terms to which they agreed. Neither law nor policy compels such an unwarranted and inequitable result.

CONCLUSION

For the reasons stated, NASP and SIIA respectfully ask that the Court affirm the judgment below.

Respectfully submitted,

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No. 14-723

IN THE

Supreme Court of the United States

ROBERT MONTANILE,

Petitioner,

v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF RESPONDENT

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IN THE

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ROBERT MONTANILE,

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v.

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF RESPONDENT

The National Coordinating Committee for Multiemployer Plans ("NCCMP") is a nonprofit, tax exempt organization that has participated for over thirty years in the development of employee benefits legislation and regulations promulgated to implement the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, and other laws affecting multiemployer plans.[1] The NCCMP's primary purposes are to

[1] Pursuant to Rule 37.6 of the Rules of this Court, the undersigned hereby state that no counsel for Petitioner or Respondent

assure an environment in which multiemployer plans can continue their vital role in providing medical, pension, and other benefits to working men and women, and to participate in the development of sound employee benefits legislation, regulations, and policy.

The NCCMP is the only national organization devoted exclusively to protecting the interests of multiemployer plans by advocating on behalf of these plans in Congress, in the courts, and in the regulatory process. Multiemployer plans provide benefits to tens of millions of American workers. Hundreds of multiemployer plans and related organizations, with a nationwide participant base, are affiliated with the NCCMP. Affiliated plans are active in every segment of the multiemployer plan universe, including the airline, building and construction, entertainment, food production, distribution and retail sales, health care, hospitality, mining, maritime, industrial fabrication, service, textile, and trucking industries. Congress has recognized that the continued well-being and security of employees, retirees, and their dependents are directly impacted by multiemployer plans and that interference with the maintenance and growth of such plans is contrary to the national public interest. *See* 29 U.S.C. § 1001(a)(1), (3), (c)(2).

Because of the broad range of experience of the NCCMP's constituent organizations, the NCCMP believes it is uniquely qualified to state the position of the trustees of multiemployer plans and to offer special insight into the impact this case will have on the efficient administration of these plans. Moreover, while the

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authored any part of this brief. Moreover, no person or entity other than the NCCMP made a monetary contribution to the preparation or submission of this brief.

NCCMP participated as amicus in both *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), and *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013), the instant case is of special importance to the NCCMP because it involves a petitioner's effort to limit the scope of relief available to a fiduciary under § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), where that fiduciary happens to be the board of trustees of a multiemployer plan.

The NCCMP and its constituent groups have a strong interest in supporting the decision below to ensure that multiemployer plans continue to have an effective, efficient, and uniform equitable remedy available to them in the federal courts to recover amounts due to the plans. More specifically, the NCCMP and its constituent groups have a strong interest in preserving the enforceability and effectiveness of self-funded multiemployer plans' subrogation and right of reimbursement provisions under § 502(a)(3) of ERISA, in accordance with the Court's decisions in *Sereboff* and *McCutchen*. Both Petitioner and Respondent have filed blanket consent to the filing of amicus curiae briefs in support of either party or of neither party.

INTRODUCTION

The decision below concerns the scope of § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), which authorizes a civil action by ERISA plan fiduciaries "to enjoin any act or practice which violates . the terms of the plan, or . to obtain other appropriate relief to enforce the terms of the plan." To proceed under § 502(a)(3), plans must seek only "those categories of relief that were typically available in equity." *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210 (2002) (quoting

Mertens v. Hewitt Assocs., 508 U.S. 248, 256 (1993)). Thus, an ERISA plan may seek recovery under § 502(a)(3) for its share of payments received from a responsible tortfeasor only if the plan's claim for relief is equitable.

In *Sereboff* this Court held that an ERISA plan could enforce its equitable claim to a portion of payments received from a third party when the terms of the plan create an equitable lien by agreement. The Court first determined that the nature of the relief sought was equitable because it sought a specific portion (the cost of the medical benefits it advanced) of specifically identified funds (the Sereboffs' settlement with the third party tortfeasor). 547 U.S. at 363-64. This Court then determined that the plan's reimbursement provision created an equitable lien by agreement, which forms a basis for appropriate "equitable relief" enforceable under § 502(a)(3) and Supreme Court precedent. *Id.* at 369. Relying on "the familiar rule of equity that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets title to the thing," Mid Atlantic could "follow a portion of the recovery into the Sereboffs' hands as soon as the settlement fund was identified." *Id.* at 364 (internal quotations omitted) (quoting *Barnes v. Alexander*, 232 U.S. 117, 121, 123 (1914)).

In *McCutchen*, the Court reinforced *Sereboff*'s treatment of equitable liens by agreement. Rejecting the ERISA plan participant's attempt to assert equitable defenses to defeat the plan's reimbursement provision, the Court explained that a lien by agreement "as its name announces – both arises from and serves to carry out a

contract's provisions" and that "enforcing the lien means holding the parties to their mutual promises." 133 S. Ct. at 1546 (internal citations omitted). "Conversely, it means declining to apply rules—even if they would be 'equitable' in a contract's absence—at odds with the parties' expressed commitments. . In those circumstances, hewing to the parties' exchange yields 'appropriate' as well as 'equitable' relief." *Id.* at 1546-47.

Sereboff and *McCutchen* are based on principles fundamental to ERISA and long recognized by this Court: attention to the terms of written plan documents and enforcement of those terms. *See, e.g., Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 300 (2009) (section 502 claims "stand[] or fall[] by the terms of the plan"); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995) (ERISA's statutory scheme is "built around reliance on the face of written plan documents"); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985) (ERISA's principal function is "to protect contractually defined benefits").

Accordingly, the majority of courts to consider the issue have held the parties to their bargain and enforced equitable liens by agreement, rejecting various attempts by participants and beneficiaries to evade their obligations. In *McCutchen*, for example, the Court held that an ERISA plan may recover medical expenses paid on behalf of a participant because of a third party's actions if the participant later recovers money from the third party, even if the participant's recovery did not make him whole. *See McCutchen*, 133 S. Ct. at 1547-48. And the majority of circuit courts to consider the dissipation issue this case presents have held, consistent with the

decision below, that an ERISA plan may enforce its claim to a portion of payments received by a third party even when the participant has spent those funds. *See AirTran Airways, Inc. v. Elem*, 767 F.3d 1192, 1198-99 (11th Cir. 2014) (collecting cases).

The case currently before the Court represents the latest attempt by a plan participant or beneficiary to avoid the agreement to which he or she is bound. Montanile contends that the Plan's right to enforce its valid equitable lien by agreement can be destroyed by his subsequent dissipation of settlement proceeds subject to the Plan's equitable lien. If adopted by this Court, Montanile's position would make an ERISA plan's reimbursement and subrogation provision unenforceable—effectively nullifying the provision—whenever a beneficiary dissipates the money he or she recovers from a tortfeasor, or would otherwise place significant administrative burdens on an ERISA plan whenever it seeks to enforce an equitable lien.

This disregard for plan terms would be devastating to multiemployer plans. Trustees of such plans heavily rely on ERISA's guarantee that plan terms will be enforced as written. Multiemployer plans are not profit-making entities. They are products of the collective bargaining process, and they serve as vehicles for providing health and retirement benefits for working men and women and their families. Often, the participants in multiemployer plans work in industries characterized by physically demanding work, such as construction and related trades and crafts, which lead to more medical claims than workers in other industries. The plans' survival is conditioned upon parties' ability to ne-

gotiate agreements that meet the wage and benefit requirements of workers while enabling their employers to remain profitable. This allows the employers involved to provide both jobs and the medical benefits that are the focus of this case.

Multiemployer plans are run by joint boards of trustees appointed by participating employers and labor organizations. Trustees are, therefore, acutely aware of the limited ways in which plans can keep up with ever-increasing health care costs: employers can contribute more money towards the plans, which may make the cost of their products or services less competitive in the market; employees can either assume a larger percentage of their health care costs through increased employee contribution rates or take cuts in pay to offset higher employer contribution rates; or plans may be forced to make cuts in benefits. These plans contain subrogation and reimbursement provisions to avoid double recovery by a single beneficiary at the expense of all other participants and beneficiaries. In a very real sense, when a participant refuses to honor these terms of the plan he deprives the remaining participants and beneficiaries of the medical benefits to which they are entitled.

Although *Sereboff* and *McCutchen* provide a narrow equitable right to reimbursement, they at least provide fiduciaries with access to the relief necessary to enforce plan terms by allowing plans to impose equitable liens by agreement. Petitioner's position, if upheld, will undermine that modest achievement by allowing a beneficiary to spend the recovery to which the plan is entitled, and then refuse to honor his

obligation to reimburse his benefit plan. The NCCMP submits this brief to urge the Court to affirm the decision below and leave to multiemployer plans the narrow, but critically important, equitable remedy under § 502(a)(3) of ERISA that is the equitable lien by agreement.

SUMMARY OF THE ARGUMENT

The Court of Appeals properly held that the National Elevator Industry Health Benefit Plan's claim under § 502(a)(3) of ERISA was permissible because it sought to enforce the terms of its plan through an equitable lien by agreement, which is enforceable even if the specifically identified funds are dissipated. Therefore, the lower court's decision should be affirmed. A multiemployer plan must be able to enforce its terms and obtain payments that rightfully belong to the plan. Otherwise, a single beneficiary's double recovery comes at the expense of all other plan participants and beneficiaries. The lower court's decision also has the effect of protecting valuable medical benefits provided to beneficiaries, which will be lost if plans do not retain an effective method to assert their equitable reimbursement rights. The narrow equitable remedy asserted by the National Elevator Industry Health Benefit Plan is crucial for benefit plans to recover overpayments in a wide range of contexts, and plans lack other effective remedies at the state and federal levels. Finally, the decision below is consistent with Congress's objectives in enacting ERISA to enforce plan terms, protect contractually defined benefits for *all* participants and beneficiaries, and preserve a uniform system for administering benefit plans.

ARGUMENT

I. IT IS CRUCIAL THAT MULTIEMPLOYER FUNDS RETAIN THE RIGHT OF REIMBURSEMENT FOR BENEFITS THAT THEY HAVE ADVANCED TO PARTICIPANTS AND BENEFICIARIES.

The outcome of this case will turn on whether ERISA plans' equitable liens by agreement may be enforced when the funds subject to such liens have been dissipated. The NCCMP agrees with and finds persuasive Respondent's analysis of the principles of equity and its conclusion that an ERISA plan's right to enforce a lien by agreement cannot be defeated by dissipation. In addition, there are numerous reasons – both practical and policy-oriented – that compel the NCCMP to advocate for this conclusion, which is necessary for the sound administration of the plans that the NCCMP represents and their continued ability to provide benefits under all circumstances.

A. Subrogation and Reimbursement Provisions in Multiemployer Plans Protect all Plan Participants and Beneficiaries.

Petitioner and its amici urge this Court to place the interests of an individual participant above the written plan document. This cannot be done without harming all other plan participants.

Participants and beneficiaries in self-funded plans of all types are directly impacted by the unenforceability of their plans' reimbursement and subrogation provisions. The United States, as amicus in *Sereboff*, and Petitioner's amicus American Association for Justice acknowledge that "an employer who self-insures di-

rectly reduces its costs by recovering those costs from a third-party." Brief for the United States as Amicus Curiae Supporting Respondent, *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006) (No. 05-260), 2006 WL 460876, at *26 n.10; *see also* Br. for Am. Ass'n for Justice as Amicus Curiae at 17 (for self-insured plans, reimbursements "will [] go directly into plan assets to reduce the fund's costs"). Without these recoveries and reimbursements, plans' increased costs must be borne by all other participants and beneficiaries.

The Eighth Circuit clearly described the consequences of failing to enforce subrogation and reimbursement plan provisions in *Administrative Committee of Wal-Mart Stores, Inc. Associates' Health & Welfare Plan v. Shank*, 500 F.3d 834 (8th Cir. 2007). In that case, the plan paid $469,216 in medical bills on behalf of a beneficiary, covering all of her medical expenses following an automobile accident. *Id.* at 835. When the beneficiary recovered $700,000 from the responsible tortfeasor, the plan asserted a lien by agreement of $469,216. *See id.* at 835-36. The beneficiary, who had placed the recovery in a special needs trust, argued that the plan's lien was not equitable and thus could not be enforced under § 502(a)(3). *See id.* at 836. In upholding the plan's right to enforce its reimbursement provision, the Eighth Circuit recognized that the interests of one participant cannot override the written plan document without harming all other plan participants.

> We acknowledge the difficulty of Shank's personal situation, but we believe the purposes of ERISA are best served by enforcing the Plan as written. Shank would benefit if we denied the Committee its right to full reimbursement, but all other plan members

> would bear the cost in the form of higher premiums. Reimbursement and subrogation provisions are crucial to the financial viability of self-funded ERISA plans, and, as a fiduciary, the Committee must "preserve assets to satisfy future, as well as present claims," and must "take impartial account of the interests of all beneficiaries." *Varity Corp. v. Howe*, 516 U.S. 489, 514 (1996).

Shank, 500 F.3d at 838; *see also Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1237 (11th Cir. 2010); *Paris v. Iron Workers Trust Fund*, 211 F.3d 1265 (table) *3 (4th Cir. 2000); *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 280-81 (1st Cir. 2000).

The facts presented in this case illustrate the effects of a double recovery on a single beneficiary at the expense of all other participants and beneficiaries in a plan. Petitioner recovered $500,000 from the responsible tortfeasor and the National Elevator Industry Health Benefit Plan ("Plan") claimed an equitable right to a share of that recovery in the amount of $121,044.02—the amount the Plan had already paid for Petitioner's medical expenses caused by the accident. Neither Petitioner nor its amici dispute that for the period of time that Mr. Montanile held the settlement funds, the Plan had an equitable lien on the portion of those funds it had advanced to Mr. Montanile. Nor do Petitioner or amici dispute that during this time, he held property that belonged to the Plan. Under the Plan's Declaration of Trust and under ERISA itself, plan assets are to be used solely for providing covered services to the Plan's participants and beneficiaries. *See* Appellant's Appendix Vol. I at 146, *Board of Trustees of the Nat'l Elevator Indus. Health Benefit Plan v. Montanile*, 593 F. App'x

903 (11th Cir. 2014) (No. 14-11678) (Restated Agreement and Declaration of Trust of the National Elevator Industry Welfare Plan Art. II, Par. 3); ERISA § 404(a)(1)(A). A single Plan participant should not be able to divert these funds for his exclusive use.

Petitioner notes that the fund subject to the Plan's lien was used to support Mr. Montanile's daughter and to maintain their home. Pet'r. Br. at 5. Petitioner also notes that the Plan has approximately $1 billion in assets and more than 500 participating employers. Pet'r. Br. at 4 n.1. While one may be sympathetic to Mr. Montanile's plight, it should also be noted that the Plan provides health benefits to over 31,000 active participants and retirees, plus tens of thousands of their dependents. The Plan paid well over $470 million in total benefit payments in 2013, the most recent year for which its tax filing is available.[2]

If the Plan were able to enforce its equitable right to reimbursement from the settlement proceeds, it could use that recovery to provide significant benefits to other participants and beneficiaries. For example, the Center

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[2] National Elevator Industry Health Benefit Plan, 2013 Form 5500 Annual Return/Report of Employee Benefit Plan at pt. II(5), Sched. H pt. II(2)(e)(4) (filed with the Dep't of Labor on Oct. 9, 2014), *available at* https://www.efast.dol.gov/portal/app/login?execution=e1s1. While the NCCMP represents the interests of large health funds like the Plan, it also represents the interests of plans that may have as little as $2 million in plan assets. If the judgment below is not affirmed, a small, seemingly well-funded multiemployer health benefit plan that has been providing benefits to a few hundred employees and dependents for decades could be rendered insolvent by one participant's successful effort to evade that plan's equitable lien by agreement by dissipating the fund subject to the lien.

for Disease Control estimates that $121,044.02 would cover the cost of all required immunizations for 115 children from birth up to age eighteen. *See Vaccines for Children Program: CDC Vaccine Price List*, Ctrs. for Disease Control & Prevention, *available at* http://www.cdc.gov/vaccines/programs/vfc/awardees/vaccine-management/price-list/ (last updated Aug. 3, 2015). Other multiemployer plans that are constituent members of NCCMP estimate that $121,044.02 would allow them to cover any of the following: annual prescription costs for thirteen cancer patients; seventy hearing aids; one month's prescription costs for 388 retirees and their eligible family members; over 1,700 speech therapy sessions; or pre-implantation treatment, entire hospital admission, and surgeon's transplant charges for one kidney transplant patient.

The disregard for plan terms urged by Petitioner would be particularly devastating to multiemployer plans' ability to provide these benefits. The reason that subrogation and reimbursement provisions serve such an important role in multiemployer plan design is in large part due to the manner in which these plans are funded. Multiemployer plans are established and funded through the collective bargaining process—once every three years or more the bargaining parties sit down to determine how much money will be directed to a self-funded multiemployer health plan over the duration of a collective bargaining agreement. With their sources of funding established through the collective bargaining process, self-funded multiemployer plans typically cannot raise employee premiums to offset increased costs of plan administration.

While funding through the collective bargaining process places limits on the assets available to self-funded multiemployer health plans, federal regulation of group health plans over the past thirty years has placed an increasing number of mandates on the rights and benefits these plans must provide. Beginning in 1986, when Congress first required plans to provide continuation coverage to employees and beneficiaries in the event of termination or other qualifying events, Congress, the Department of Labor, the Internal Revenue Service, and the Department of Health and Human Services have steadily increased the number of mandated benefits required of self-funded health plans. ERISA, as amended through 2009, now requires plans to provide continuation coverage to employees on qualified family or medical leave, to honor qualified medical child support orders, to provide reconstructive surgery following a covered mastectomy, to limit restrictions on benefits for preexisting conditions, to eliminate limits on hospital length of stays connected with childbirth, and to establish parity between mental health and substance abuse benefits and medical benefits.[3] And the

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[3] *See* Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82 (1986); Family and Medical Leave Act of 1993 (FMLA), Pub. L. No. 103-3, 107 Stat. 6 (1993); Child Support Performance and Incentive Act of 1998, Pub. L. No. 105-200, 112 Stat. 645 (1998); Women's Health and Cancer Rights Act, Pub. L. No. 105-277, tit. IX, 112 Stat. 2681-436 (1998); Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936; *Standards for Privacy of Individually Identifiable Health Information*, 65 Fed. Reg. 82,462 (Dec. 28, 2000) (codified at 45 C.F.R. pts 160 and 164); Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), Pub. L. No. 104-204, tit. VI, 110 Stat. 2935 (1996); Mental Health Parity Act of 1996 (MHPA), Pub. L. No. 104-204, tit. VII, 110 Stat.

impact of the foregoing requirements pales in comparison to that of the Patient Protection and Affordable Care Act ("ACA"). Pub. L. No. 111-148, 124 Stat. 119 (2010). Among other things, the ACA requires group health plans (including self-funded health plans) to eliminate lifetime and annual benefit limits for essential benefits, to provide dependent coverage for adult children up to age 26, to eliminate cost-sharing for preventive services and immunizations, to limit rescissions in eligibility to cases of fraud and intentional misrepresentation, to eliminate any pre-existing condition exclusions, and to eliminate waiting periods in excess of 90 days.

More than ever, trustees of multiemployer health plans must wrestle with escalating health care costs, including the costs of complying with new, expensive ACA minimum coverage requirements, at a time when many of those sectors of the economy where employees and their dependents are most likely to receive healthcare benefits through multiemployer plans are either in decline or are still recovering from the nation's worst recession since the Great Depression. With rising costs and few options for increasing funding, multiemployer plans must be able to rely on the enforceability of the subrogation and reimbursement provisions written into plan documents.[4]

2944 (1996); Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 110-343, tit. V.B, 122 Stat. 3881 (2008). This is not an exhaustive list, but it does include the more burdensome changes in the law since ERISA's enactment.

[4] Petitioner's suggestions that the summary plan description ("SPD"), which contains the reimbursement and subrogation provision in this case, does not constitute a "plan document" and

Preserving the link between effective enforcement of reimbursement and subrogation provisions and preservation of plan assets for present and future claims is critical to the self-funded multiemployer plans that are among the NCCMP's constituents. Such plans must ensure that contributions paid in accordance with the terms of collective bargaining agreements are sufficient to cover the costs of providing benefits. Although the vigorous efforts of trustees of such plans to enforce reimbursement and subrogation provisions may appear harsh when viewed from the perspective of a severely injured participant or beneficiary, in fact, the trustees are fulfilling their fiduciary duty to ensure that the plan may continue to provide benefits to all participants and beneficiaries. *See* ERISA § 404(a)(1)(A), ("a fiduciary shall discharge his duties with respect to a plan solely in the interest of participants and beneficiaries . . and for the exclusive purpose of . providing benefits to participants and their beneficiaries; and defraying reasonable expenses of administering the plan.").

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does not set forth the terms of the plan must be rejected. Pet'r Br. at 7 n.6, 8-11, 40 n.22. First, Petitioner expressly waived that argument before this Court. *Id.* at 13 n.8. Second, this Court has recognized that enforceable plan terms may be found in more than one document, *see Curtiss-Wright Corp.*, 514 U.S. at 83, and that an SPD may be enforceable under Section 502 of ERISA if it does not conflict with terms specified in other, governing plan documents, *see CIGNA Corp. v. Amara*, 563 U.S. 421 (2011). Finally, at least three circuits have reviewed the same SPD at issue here and have recognized that it functions as the controlling ERISA plan in the absence of a separate plan document. *See Bd. of Trs. of the Nat'l Elevator Indus. Health Ben. Plan v. Moore*, — F.3d —, No. 14-4048, 2015 WL 5010985, at *4-6 (6th Cir. Aug. 25, 2015) (collecting cases).

B. The Decision Below Protects Beneficiaries' Ability to Obtain Immediate Medical Benefits when Injuries are Caused by Third Parties.

Self-funded multiemployer benefit plans are not obligated by any law to pay medical benefits when a participant or beneficiary is injured by a third party. The result of the position advanced by Petitioners, for the Court to sharply constrict benefit plans' ability to enforce equitable claims over a portion of compensation received by tort victims, is that beneficiaries will be left with no medical coverage when they need it most, after an unexpected accident caused by a tortfeasor.

Although ERISA establishes a comprehensive regulatory scheme for benefit plans in general, it does not mandate any minimum substantive content for welfare benefit plans in particular. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983); *Hamilton v. Air Jam., Ltd.*, 945 F.2d 74, 78 (3d Cir. 1991). As a result, employers "have large leeway to design disability and other welfare plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). In *Metropolitan Life Insurance Company v. Massachusetts*, the Court held that ERISA "does not regulate the substantive content of welfare-benefit plans." 471 U.S. 724, 732 (1985). ERISA generally leaves it to plan sponsors "to adopt, modify, or terminate welfare plans." *Curtiss-Wright Corp.*, 514 U.S. at 78; *see Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).

The vast majority of multiemployer plans affiliated with the NCCMP have not agreed to pay medical benefits for injuries caused by third parties. The written plans commonly provide that benefits are not payable

if a sickness or injury is the responsibility of a third party. However, recognizing that beneficiaries need to pay for extraordinary medical expenses in the event of unexpected illness or injury, plans allow for the advancement of benefits. That advance, however, is commonly conditioned on the beneficiary's promise to honor the benefit plan's equitable right to a portion of compensation if and when the beneficiary obtains a recovery from the responsible third party. *See, e.g., Kress v. Food Emp'rs Labor Relations Ass'n*, 391 F.3d 563, 565 (4th Cir. 2004) (involving plan's refusal to pay benefits for injuries from auto accident when beneficiary refused to acknowledge equitable reimbursement right); *Copeland Oaks v. Haupt*, 209 F.3d 811, 812 (6th Cir. 2000) (same); *Cagle v. Bruner*, 112 F.3d 1510, 1513 (11th Cir. 1997) (same).

The terms of a typical plan of benefits are illustrated by the plan considered by the Fourth Circuit in *Kress*:

> Waiting for a third party to pay for these injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court), and your creditors will not wait patiently. Because of this, as a service to you, the Fund will pay your (or your eligible dependent's) expenses based on the understanding that you are required to reimburse the Fund in full from any recovery you or your eligible dependent may receive, no matter how it is characterized. This process is called "subrogation." .... The Fund extends benefits to you and your dependents only as a service to you. The Fund must be reimbursed if you obtain any recovery from another person or entity's insurance coverage.

391 F.3d at 566. Thus, far from having contracted to

bear the risk associated with the costs of injuries caused by third parties, benefit plans typically expressly disavow any obligation to pay benefits under those circumstances.

However, recognizing the difficult circumstances presented to beneficiaries, benefit plans typically agree to advance medical costs to tide over a beneficiary in difficult times, *but only if* the beneficiary promises to reimburse the benefit plan later. As emphasized by the Fourth Circuit, these plan provisions

> broadened rather than narrowed the options of Fund participants. Nothing required [the beneficiary] to accept the subrogation option; he was free to reject it and commence litigation at once, with no obligations whatever to the Fund. But if he did accept the Fund's offer, and then recovered in tort, it was not wrongful for the Fund to seek to recoup this expenditure to provide for future participants who may find themselves in similarly straitened circumstances. The Fund "must serve the best interests of all Plan beneficiaries, not just the best interest of one potential beneficiary."

Id. at 570-71 (footnote omitted) (citing *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 234 (4th Cir. 1997)). It is the voluntary nature of these advanced payments that clearly establishes the need for an *equitable* remedy of reimbursement as opposed to the legal remedy of a breach of contract.[5]

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[5] Petitioner's amicus, the American Association for Justice, argues that subrogation and reimbursement provisions constitute "illusive" coverage unfair to beneficiaries, and that restricting benefit plans' ability to enforce such provisions is appropriate

If the Court restricts benefit plans' ability to obtain equitable liens by agreement under these circumstances, as argued by Petitioner, the result will not be a greater recovery by beneficiaries in personal injury lawsuits. Instead, benefit plans will respond by simply not advancing these payments in the first place, leaving beneficiaries to deal with medical bills, creditors, and delays on their own through the uncertain and lengthy process of personal injury lawsuits. This cannot be good public policy.

Reducing benefit plans' equitable remedies, as urged by Petitioner, will create hardship for beneficiaries in another form as well. Currently, as described above, plans typically advance benefits to beneficiaries in their times of need, based on a promise to reimburse in the event that a future recovery is obtained. In some cases, at a point in time far in the future, the beneficiary may eventually recover a payment from the tortfeasor and be required to reimburse the plan. However, far more commonly, the beneficiary decides not to pursue an action against the responsible tortfeasor, or, based on the uncertainties and expense of litigation, agrees to a settlement for less than full compensation. In these common scenarios, the beneficiary will retain the benefit of having had medical expenses paid on his or her behalf

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because beneficiaries are merely receiving the benefits to which they are contractually entitled in the first place. Br. for Am. Ass'n for Justice as Amicus Curiae at 28. Thus, according to Amicus, because participants "have paid for" coverage, there is no policy justification to require beneficiaries to reimburse medical plans out of tort recoveries from third parties. *Id.* As detailed by the plan language quoted above, this argument ignores that many benefit plans do not, in fact, contract to bear the risk to pay medical benefits when injuries or sicknesses are caused by a third party.

without having to engage in legal action and without any obligation to reimburse the plan (beyond any amount recovered). This benefit will be lost to beneficiaries if plans stop advancing benefits in exchange for the right to an equitable claim of reimbursement.

C. Preserving a Meaningful Equitable Remedy in the Face of Dissipation is Necessary in Many Subrogation and Reimbursement Cases and in Other Types of Plan Recoveries as Well.

Petitioner claims that dissipation's destruction of a plan's equitable lien by agreement will occur in only a small fraction of cases where recoupment of benefits is sought – those "truly exceptional cases" where "the participant uses the settlement funds to purchase services (*e.g.*, childcare) or consumable goods (*e.g.*, food) from a bona fide purchaser for value." Pet'r Br. at 44-45. Petitioner contrasts such a situation with scenarios in which it claims funds can be traced and recouped by the plan, such as where a participant uses funds to obtain an asset, gives the funds to another person, or uses the funds to obtain goods or services from another person with notice of the lien. Pet'r Br. at 44.

The NCCMP disagrees that dissipation cases like Mr. Montanile's are "truly exceptional." If a participant could claim that a plan's equitable lien is destroyed to the extent that the participant paid his or her bills or purchased groceries after taking possession of settlement funds or other funds subject to an equitable lien by agreement, practically all participants who receive such funds would be able to void those liens to the detriment of their plans and their fellow participants. In a situation like *Montanile*, where a participant is in-

jured, it is even more likely that he or she will be able to claim dissipation of funds shortly after they are received because the participant most likely would have been unable to work while injured and may have accrued significant financial obligations during that time.[6]

Moreover, dissipation and destruction of plans' equitable liens by agreement will affect not only health and welfare plans but also all other types of plans, including pension plans. Petitioner and its amici acknowledge this fact. *See* Pet'r Br. at 21; Br. for AARP as Amicus Curiae at 3; Br. for Am. Ass'n for Justice as Amicus Curiae at 1. Indeed, AARP's entire amicus brief is devoted to the issue of overpayments in the pension plan context.

Overpayments from pension plans may result from a number of factual scenarios. For example, plans, which rely on participants and beneficiaries to alert them to life changes that affect benefits, may continue to make erroneous automatic benefit payments even though a participant has died if the plan is not alerted in a timely manner of the death. Benefits may also be obtained through fraud or as the result of miscalculations or ac-

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[6] Petitioner claims to have found "no evidence of a 'dissipation explosion'" in the jurisdictions that have adopted his position. Pet'r Br. at 42 n.23. This observation ignores the fact that such evidence would not be readily apparent since plans would be unlikely to bring claims against participants who have claimed dissipation in light of the Eighth and Ninth Circuits' decisions in *Treasurer, Trs. of Drury Indus., Inc. Health Care Plan & Tr. v. Goding*, 692 F.3d 888 (8th Cir. 2012), and *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083 (9th Cir. 2012).

cidental payment of a benefit to the wrong person. In all of these scenarios – some of which may not be discovered for some time – the plan must be able to enforce its terms to recover overpayments, whether or not the recipient has spent the overpaid funds on goods or services.

Kroop v. Rivlin, Case 04 Civ. 1401, 2004 WL 2181110 (S.D.N.Y. Sept. 27, 2004), illustrates the consequences of adopting Petitioner's position. In *Kroop*, the court found that a pension plan had no right to recoupment where a pensioner's son misrepresented that his father was alive for eight years while cashing his father's pension checks. The court ruled that, because the pensioner's son had spent the proceeds of the checks he had fraudulently cashed and no longer had possession of those funds, under *Great-West*, the plan's recoupment efforts were legal and not equitable and, therefore, relief was unavailable under ERISA. *Id.* at *2. Since *Sereboff*, Courts of Appeals have avoided the result of *Kroop* by holding that a plan's equitable lien by agreement attaches when funds are received and that subsequent dissipation is irrelevant. *See Elem*, 767 F.3d at 1198-99 (collecting cases). If these cases are overruled and Petitioner's position prevails, plans will have no right to recover funds paid to ineligible parties simply because the recipient of the funds spent them on normal costs of daily life.[7]

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[7] *Kroop* also illustrates the limits of Petitioner's assertion that a plan can recover amounts due to it from a beneficiary by simply deducting those amounts from that beneficiary's future plan payments. *See* Pet'r Br. at 21-22. In *Kroop*, or any other case where

Plan terms, especially in the pension context, are of paramount importance in promoting ERISA's principal goal of "protect[ing] contractually defined benefits." *Mass. Mut. Life Ins. Co.*, 473 U.S. at 148. In its amicus brief, AARP advocates for the interests of the few overpaid pension plan participants, but all plan participants suffer when plans do not have a full complement of tools to recoup overpayments.

In the context of a defined benefit pension plan–a plan that consists of a general pool of assets and gives each eligible participant the right to a certain level of accrued benefits, usually a fixed periodic payment commencing at normal retirement age–the plan must ensure that benefits are fully funded according to complex actuarial calculations. If terms are effectively added to the plan, as they would be if certain participants were allowed to keep erroneously paid benefits over and above their entitlement under the plan, the actuarial soundness of the plan may be jeopardized to the detriment of all participants. *See Shields v. Local 705, Int'l Bhd. of Teamsters Pension Plan*, 188 F.3d 895, 905 (7th Cir. 1999) (Posner, C.J., concurring) ("If terms are added . that appear nowhere in the plan documents upon which the actuarial calculations are based, that the actuaries who designed the funding mechanism in the plan did not know about . the plan may turn out to be seriously underfunded. [T]he actuarial impli-

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benefits are paid by the plan under circumstances where no entitlement to benefits existed, it would be impossible for the plan to recover them by offsetting future benefits. Of course, in health care cases, by definition, there is no possibility for a plan to offset future benefits because health benefits are paid only as needed for specified medical purposes.

cations are graver the more workers are involved. And it is particularly clear in a case . . . in which the defined-benefit plan is a multiemployer plan." (internal citations omitted)).

Similarly, in a defined contribution plan, contributions are paid into the plan and, upon retirement, each participant is entitled to the funds in his or her account. Under this plan design, an overpayment to one participant means that a participant who is paid more than the amount he or she has earned under the terms of the plan has been overpaid at the direct expense of another participant. The very narrow remedy of an equitable lien permitted by the court below is vital to benefit plans in any context in which recovery of plan assets is necessary.

II. BENEFIT PLANS DO NOT HAVE ALTERNATIVE UNIFORM OR ADEQUATE REMEDIES TO RECOVER MONEY IN EQUITY.

Petitioner and its amici suggest that benefit plans really do not need an equitable remedy under § 502(a)(3) of ERISA when the disputed funds have been spent because they have other adequate options to obtain the funds before they are dissipated. They argue that plans can largely protect their rights to reimbursement by intervening in state court lawsuits or by relying on participants' tort attorneys' ethical obligations to hold the funds until the ERISA plan has an opportunity to act. *See* Pet'r Br. at 42-43; Br. for United States as Amicus Curiae at 29-31; Br. for Am. Ass'n for Justice as Amicus Curiae at 24-26. These arguments should be rejected.

As an initial matter, the Petitioner's suggestion that benefit plans should intervene in state court lawsuits

ignores the fact that the vast majority of state court tort actions end in settlement. *See* U.S. Dep't of Justice, Bureau of Justice Statistics, NCJ 233094, *Punitive Damage Awards in State Courts, 2005* at 2 tbl.2 (Mar. 2011), *available at* http://bjs.gov/content/pub/pdf/pdasc05.pdf. Therefore, there will usually not be a state court lawsuit in which to intervene in the first place.

Petitioner's suggestion that benefit plans have adequate remedies in various state court jurisdictions also contravenes Congress's explicit purpose to obtain uniformity for benefit plans when it enacted ERISA. The purpose of the Act was to provide plans a uniform set of administrative procedures, rather than making them comply with a different set of procedures for processing claims and disbursing benefits in each state. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-57 (1995) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)). When applying this Congressional purpose to subrogation and reimbursement provisions in particular, this Court held that the "[a]pplication of differing state subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990); *see also* ERISA § 514, 29 U.S.C. § 1144 (establishing the preemption of state laws that relate to ERISA benefit plans).

Intervention in state court tort lawsuits does not present a uniform set of procedures to address benefit plans' equitable rights of reimbursement and subrogation. If a beneficiary's tort action is pending, and as-

suming that the benefit plan is even aware of the lawsuit, benefit plans will be required to become experts in the intricacies of each state's tort recovery laws. They also will be required to monitor each jurisdiction's peculiar court rules and to hire local attorneys to protect the plans' interests. In addition, these state court actions will be located in any jurisdiction in which a benefit plan's beneficiary might travel or reside. As such, the need to defend the benefit plan's interests in far-flung jurisdictions will increase the plan's administrative expenses. In creating a federal remedy exactly for these situations, Congress was careful to craft a provision that allows benefit plans to sue in a convenient forum to preserve plan assets. *See* ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2) (providing an action may be brought in the district where the plan is administered). The result of losing a uniform equitable remedy in the federal courts will be increased administrative costs to these benefit plans and a concomitant reduction in benefits for the plans' participants and beneficiaries.

Petitioner next suggests that ERISA plans may rely on attorney rules of professional conduct, which caution personal injury attorneys not to disburse third party recoveries when the funds are subject to dispute, to protect benefit funds from dissipation. See Pet'r Br. at 42. Attorney ethical obligations, however, cannot substitute for enforcement of a plan's recovery rights. First, ERISA plans may not be aware of a recovery and thus will be unable to notify the beneficiary's counsel that a portion of the recovery belongs to the plan. Second, like tort actions, professional rules of responsibility vary from state to state, and multiemployer ERISA plans can ill-afford to divert scarce resources to becoming expert in the professional obligations of each

state's personal injury plaintiffs' bar. Moreover, even if a plan took action against the attorney for ethical violations, it would not be made whole. Discipline of lawyers for violations of their ethical obligations typically takes the form of admonition, censure, suspension of practice, or disbarment, not recoupment of funds owed to the plan.

Finally, even if a plan could show that a beneficiary's personal injury attorney improperly disbursed a plan's share of recovery from a tortfeasor, the plan has no cause of action (aside from § 502(a)(3)) against the attorney unless the attorney is a party to the subrogation agreement. *See Goding*, 692 F.3d at 894-95 (finding no implied contract between attorney and plan to honor plan's subrogation agreement unless the attorney signs the agreement); *AC Hous. Lumber Co. Emp. Health Plan v. Berg*, 407 F. App'x 208, 209 (9th Cir. 2010) (same); *Hotel Emps. & Rest. Emps. Int'l Union Welfare Fund v. Gentner*, 50 F.3d 719, 720-21 (9th Cir. 1995) (same).

The Circuit split on the issue presently before the Court clearly illustrates that beneficiaries who have received payments from the responsible tortfeasors and their attorneys often do not act in good faith with regard to their obligations. In no fewer than four cases regarding dissipation of settlement proceeds—not including the decision below—the beneficiaries and their attorneys worked together to defeat plans' equitable rights by dissipating or disbursing assets. *See Elem*, 767 F.3d at 1195 (beneficiary and her attorney "conspired to hide and disburse settlement funds she received" to avoid reimbursing welfare plan); *Cent. States, S.E. and S.W. Areas Health & Welfare Fund v.*

Lewis, 745 F.3d 283, 284-85 (7th Cir. 2014) (beneficiary's attorney refused to release any settlement proceeds to welfare plan, even after court order to do so, resulting in contempt finding); *Goding*, 692 F.3d at 892 (beneficiary's personal injury attorney twice acknowledged plan's reimbursement provisions, but disbursed all proceeds within a month after settlement); *Longaberger Co. v. Kolt*, 586 F.3d 459, 462 (6th Cir. 2009) (although plan had advanced beneficiary over $113,000 in medical fees and beneficiary's personal injury attorney knew of plan's reimbursement provision, attorney disbursed all but $1,000 in settlement funds). *See also Moore*, 2015 WL 5010985 at *2 (describing the lengths to which a beneficiary's attorney sought to shut out the plan from any and all rights to settlement proceeds). In these situations, which unfortunately occur more frequently than the Petitioner believes, a uniform equitable remedy is required to enforce the terms of the plan.

III. THERE ARE NO "COMPETING GOALS" UNDER ERISA THAT WOULD BE SERVED BY REVERSING THE DECISION OF THE LOWER COURT.

Petitioner and its amici assert that further reducing plans' equitable remedies under § 502(a)(3) would properly provide "balance between the competing goals of ERISA." Pet'r Br. at 16, 18, 21-22; *see also* United Policyholders Br. as Amicus Curiae at 16-17. But there are no policy goals in the statute that would reach the result sought by Petitioner: allowing one participant to violate the terms of the plan to create a windfall for himself at the expense of all other participants and beneficiaries in

the plan.[8] To the contrary, ERISA fiduciaries, such as the trustees of multiemployer plans, have a "duty to all beneficiaries to preserve limited plan assets" and "prevent . . . windfalls for particular employees." *Conkright v. Frommert*, 559 U.S. 506, 520 (2010). In fact, allowing multiemployer plans to enforce equitable liens by agreement set forth in plan terms honors the fundamental goals of ERISA: to protect contractually defined benefits for *all* participants and beneficiaries, *see Mass. Mut. Life Ins. Co.*, 473 U.S. at 142, to enable plans to be administered according to a uniform regime, *see Conkright*, 559 U.S. at 517, and to preserve assets to satisfy future, as well as present claims, *see Varity*, 516 U.S. at 514.

Far from advancing any of the interests identified by the Court, the Petitioner's proposed rule cuts against all of them. Petitioner's rule advances the interests of single plan participants over all others and thereby threatens plans' ability to provide benefits for all participants and beneficiaries. *See Mass. Mut. Life Ins. Co.*, 473 U.S.

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[8] Petitioner cites *Mertens* for balancing ERISA's "competing goals" to benefit employees on the one hand, and contain pension costs on the other. Pet'r. Br. at 18, 22 (citing *Mertens*, 508 U.S. at 263). However, the Court's discussion of containing pension costs in *Mertens* had to do with the possibility that these costs would increase if pension plans' non-fiduciary service providers were liable for all direct and consequential damages suffered by the plan. *See Mertens* at 262-63. Here, as explained at Section II, *supra*, the costs of plan administration will increase if plans are required to make herculean efforts to recover funds that they are now able to recover through equitable liens by agreement. Therefore, if anything, the Court's observations about ERISA's competing goals and its recognition of the nexus between the costs of plan administration and plans' ability to provide benefits in *Mertens* support the Respondent's position and not Petitioner's.

at 142. Moreover, by allowing a broad loophole for participants subject to equitable liens by agreement who are able to claim dissipation, Petitioner's rule destroys uniform enforcement of plans' reimbursement provisions. *See Conkright*, 559 U.S. at 517. Finally, Petitioner's position threatens the ability of plans to satisfy future claims by creating an avenue for participants to keep funds to which they lost entitlement or were never entitled to have. *See Varity*, 516 U.S. at 514.

At its core, the Petitioner and its amicis' objections to benefit plans' equitable reimbursement remedies are based on a perception that such a remedy is harsh and unfair. This overlooks the "commonplace economic calculus" present in every personal injury lawsuit. *Kress*, 391 F.3d at 570. According to the Fourth Circuit:

> Attorneys considering taking a case on contingency commonly factor the likelihood of success and the magnitude of recovery into their decision. "Many tort claims involve considerable risk and insufficient reward. Attorneys, however, carefully screen these claims and reject a large portion, including most denominated as high risk." . . If the participant and his attorney conclude that private litigation will not produce a sufficient recovery to make the litigation worthwhile, they need not bring the case.

Id. (internal citation omitted.) Thus, harsh results are not caused by benefit plans enforcing a right to reimbursement and subrogation. Instead the "unfairness" is often an inherent part of the litigation process that has been described, in this context, as being "like a lottery ticket." *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1298 (7th Cir. 1993). In fact, far from creating

hardships, the availability of subrogation and reimbursement serves to shift the risk of an uncertain recovery onto the *benefit plan* and away from the beneficiary. *See id.* at 1297. This is because, by advancing medical benefits to a beneficiary in anticipation of a possible equitable claim to proceeds obtained in the future, the "lottery ticket" of uncertain payment for medical expenses is transferred from the beneficiary to the benefit plan. *Id.* at 1298. Where the tortfeasor subsequently gives the beneficiary money to cover expenses the plan has already paid, preserving a limited equitable remedy under § 502(a)(3) is the only outcome consistent with ERISA's text and purpose.

CONCLUSION

For the foregoing reasons, the NCCMP respectfully urges the Court to affirm the decision of the Court of Appeals.

Respectfully submitted,

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IN THE
Supreme Court of the United States

ROBERT MONTANILE,
Petitioner,
v.
BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,
Respondent.

On Writ of Certiorari to the
United States Court of Appeals
for the Eleventh Circuit

BRIEF OF UNITED POLICYHOLDERS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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BRIEF OF *AMICUS CURIAE* UNITED POLICYHOLDERS

INTEREST OF THE *AMICUS CURIAE*[1]

United Policyholders ("UP") is a non-profit 501(c)(3) organization founded in 1991 that serves as a voice and an information resource for insurance consumers in all 50 states. As part of its mission, UP monitors the implementation and application of laws and rules under the Employee Retirement Income and Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, because a substantial percentage of the insurance market is governed by ERISA.

UP's work is divided into three program areas: *Roadmap to Recovery* (claim assistance), *Roadmap to Preparedness* (promoting insurance/financial literacy) and *Advocacy and Action* (advancing the interests of insurance consumers in courts of law, before regulators and legislators, and in the media). Donations, foundation grants and volunteer labor support the organization's work. UP does not accept funding from insurance companies.

Advancing the interests of policyholders through participation as *amicus curiae* in insurance-related cases throughout the country is an important part of UP's work. UP's reputation as a reliable

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[1] Pursuant to Supreme Court Rule 37.6, *amicus curiae* states that no person or entity other than the *amicus curiae*, and its undersigned counsel, made a monetary contribution to the preparation or submission of this brief. No attorney for any party authored this brief in whole or in part. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office in accordance with Supreme Court Rule 37.3(a).

friend of the court was enhanced when its *amicus curiae* brief was cited in this Court's opinion in *Humana v. Forsyth,* 525 U.S. 299 (1999), and its arguments were adopted by the Texas Supreme Court in *Excess Underwriters at Lloyd's, London, et al. v. Frank's Casing Crew & Rental Tools Inc.,* 246 S.W.3d 42 (Tex. 2008), as well as by the California Supreme Court in *Vandenberg v. Superior Court,* 88 Cal. Rptr.2d 366 (Cal. 1999) and numerous other proceedings including *TRB Investments, Inc. v. Fireman's Fund Ins. Co.,* 145 P.3d 472 (Cal. 2006). Other ERISA cases in which UP has been granted leave by the Supreme Court to participate as *amicus curiae* include: *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604 (2013); *US Airways v. McCutchen,* 133 S. Ct. 1537 (2013); *Hardt v. Reliance Standard Life Insurance Co.*, 130 S. Ct. 2149 (2010); *Metro. Life Ins. Co. v. Glenn,* 554 U.S. 105 (2008); *Aetna Health, Inc. v. Davila,* 542 U.S. 200 (2004); and *Rush Prudential HMO v. Moran,* 536 U.S. 355 (2002).

We seek to assist the Court in this case because of its potential impact on millions of employees and policyholders enrolled in employee benefit plans governed by ERISA.

SUMMARY OF ARGUMENT

This case does not involve disability benefits, but a number of the cases involved in the circuit split are disability benefit cases;[2] and the Court's decision could have broad-reaching implications for participants in disability plans as well as health plan participants.

Most, if not all, employer-sponsored disability benefit plans coordinate benefits with other sources of disability income, the most important of which are Social Security benefits. Because a Social Security disability claim may take months, if not years, to resolve, and since the outcome is uncertain, disability benefit plans normally issue full benefit payments to claimants, and then seek reimbursement of the overpaid benefits in the event Social Security disability benefits are subsequently awarded.

If a disability claimant fails to reimburse the plan, the disability plan may reduce benefits prospectively until the overpayment is recovered. *See, e.g., Northcutt v. GM Hourly-Rate Emple.*

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[2] *See Thurber v. Aetna Life Ins. Co.*, 712 F.3d 654 (2d Cir. 2013), *cert. denied* 134 S. Ct. 2723 (2014) (affirming right of ERISA plan administrator to recover overpaid disability benefits from claimant's general assets); *Funk v. CIGNA Group Ins.*, 648 F.3d 182 (3d Cir. 2011) (same); *Cusson v. Liberty Life Assurance Company*, 592 F.3d 215 (1st Cir. 2010) (same); *Gutta v. Standard Select Trust Ins. Plans*, 530 F.3d 614 (7th Cir. 2008) (same); *but see Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083 (9th Cir. 2012), *cert. denied* 133 S. Ct. 1242 (2013) (deeming ERISA lien unenforceable).

Pension Plan, 467 F.3d 1031, 1035-38 (7th Cir. 2006) (acknowledging that disability plan administrators have a right of setoff to recoup the overpayment). If, however, the payment of disability benefits has ceased, then so long as the benefit plan contains a right of reimbursement comparable to the "Acts of Third Parties" provision that was the subject of *Sereboff v. Mid Atl. Med. Servs.*, 547 U.S. 356 (2006), the plan may seek reimbursement pursuant to Section 502(a)(3) of the Employee Retirement Income and Security Act ("ERISA"), 29 U.S.C. § 1132(a)(3).

However, unlike other funds from which an ERISA welfare benefit plan might seek reimbursement, a retroactive award of Social Security disability benefits is subject to Section 207 of the Social Security Act, 42 U.S.C. § 407, which prohibits the assignment or attachment of Social Security benefits. To circumvent this statutory bar, a disability plan seeking to recoup an overpayment following a Social Security award must thus attempt to characterize its claim as asserting a lien on the overpaid disability benefits and not as a claim to be reimbursed from the Social Security benefits. Yet once the disability benefits have been dissipated and the only funds remaining are the Social Security payments, such reimbursement suits by the plan are indistinguishable from garnishment proceedings prohibited by 42 U.S.C. § 407.

The rule advanced by the Ninth Circuit in *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083 (9th Cir. 2012), *cert. denied*, 133 S. Ct. 1242 (2013), and the Eighth Circuit in

Treasurer, Trustees of Drury Indus., Inc. Health Care Plan & Trust v. Goding, 692 F.3d 888 (8th Cir. 2012), *cert. denied*, 133 S. Ct. 1644 (2013), prohibits ERISA fiduciaries from imposing a lien seeking recovery from dissipated or untraceable assets because such a recovery constitutes legal, not equitable, relief. The impact of that rule on disability plans will be small, because plans may reduce prospective benefits to satisfy their overpayments in most situations. And the overwhelming majority of disability claimants who qualify for Social Security benefits will also continue receiving benefits. Indeed, this Court has ruled that the termination of disability plan benefits to a participant who has been awarded Social Security benefits suggests "procedural unreasonableness." *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 118 (2008). In the rare instance where the disability benefit participant is no longer receiving benefits from the plan, it is often the disability plan, and not the claimant, that has broken its promise. The rule adopted by the Eighth and Ninth Circuits thus furthers the salutary purpose of both ERISA and the Social Security Act by ensuring that vulnerable plan participants are protected from actions by insurance companies and other plan administrators who abnegate their fiduciary duties in search of profits. *See id.*

Adopting the view presented by Petitioner will therefore ensure that the remedies available to a fiduciary under ERISA § 502(a)(3) maintain their equitable character as well as observe the letter of Section 207 of the Social Security Act prohibiting the assignment of Social Security benefits.

ARGUMENT

I. Equitable Liens by Agreement Are Not Enforceable Against Social Security Disability Benefits Pursuant to 42 U.S.C. § 407

A. How Long-Term Disability Benefits Coordinate with Social Security and Other Benefits

Employer-sponsored disability insurance provides a critical safety net for U.S. workers. At least 32.1 million people in the United States receive disability insurance coverage through their employers.[3] Of that number, approximately 653,000 people receive disability payments.[4]

Group disability insurance plans typically offer income replacement at a rate equivalent to 60% of the employee's pre-disability income.[5] Most plans provide that disability benefits may be reduced by "other income benefits," including Social Security disability benefits (both primary and dependent), worker's compensation benefits, and disability pension benefits, with Social Security disability benefits comprising the largest share. Over 70% of long-term disability claimants also concurrently

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[3] The most recent data available is from 2013. Council for Disability Awareness, *2014 Long Term Disability Claims Review* 1 (2014) (*LTD Claims Review*), *available at* http://www.disabilitycanhappen.org/research/CDA_LTD_Claims_Survey_2014.pdf.

[4] *Id.* at 3.

[5] U.S. Dep't of Labor, Bureau of Labor Statistics, *National Compensation Survey: Employee Benefits in the United States* 305 tbl. 30 (Mar. 2014), *available at* http://www.bls.gov/ncs/ebs/benefits/2014/ebbl0055.pdf.

receive Social Security disability benefits.[6] In contrast, only four to six percent of long-term disability claimants receive worker's compensation and disability pension benefits, respectively.[7]

Coordination of long-term disability benefits with Social Security benefits is desirable, in that it reduces the cost to employers of offering these plans and ensures that disability claimants do not "double dip" by receiving more than the percentage of income replacement promised by the plan. Unfortunately, the Social Security disability claim adjudication process can last months, if not years.[8] To bridge the gap between the onset of disability and the award of Social Security benefits and protect against the uncertainty of the claimant even meeting the arduous Social Security disability standards set forth in 42 U.S.C. § 423(d)(1)(A), most disability insurers issue unreduced payments in exchange for a promise by the recipient to repay those benefits once Social Security is awarded.

The typical disability plan contains a two-tiered definition of disability that pays benefits for the first 24 months to a claimant who is unable to perform the material duties of the employee's "own occupation."[9] After 24 months, benefits remain

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[6] *LTD Claims Review*, *supra* note 3, at 4.

[7] *Id.* at 3; Robert W. Beal *et al.*, *Group Long-Term Disability Benefit Offset Study – 2012* 33 tbl. V(a) (July 2013), *available at* http://www.soa.org/Files/Research/Projects/research-2013-group-ltd-offset-update.pdf.

[8] *Id.* at 22 tbl. III(s).

[9] Advisory Council on Employee Welfare and Pension Plans, *Managing Disability Risks in an Environment of Individual*

payable if the disability renders the employee from engaging in "any occupation" for which the employee is qualified by education, training or experience. *Id.* The Social Security Administration utilizes a more stringent definition of disability than either the "own occupation" or "any occupation" definition of disability in the typical disability policy, defining "disability" as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than 12 months[.]" 42 U.S.C. § 423(d)(1)(A).

Because a termination of benefits is, in most situations, inconsistent with an award of Social Security disability benefits under the Social Security Act's stringent standard, an insurer attempting to recoup overpaid disability benefits should usually have a future stream of benefits from which the overpayment can be recovered. *See, e.g., Northcutt*, 467 F.3d at 1035-38 (affirming the right of ERISA plan administrator to reduce long-term disability payments prospectively). If, however, the claimant is no longer receiving disability benefits at the time of the Social Security award, the plan's options to seek reimbursement are limited. ERISA preempts all state laws that "relate to" an employee benefit plan, including a common law breach of contract action brought by a plan to enforce a contractual reimbursement provision. 29 U.S.C. § 1144(a). Thus, the plan's only recourse, so long as the plan contains

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Responsibility 11 (Dec. 2012), *available at* http://www.dol.gov/ebsa/pdf/2012ACreport2.pdf.

appropriate reimbursement language, is to file suit under Section 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizing suits for "other appropriate equitable relief."

Section 502(a)(3) has been interpreted to provide only "those categories of relief that were typically available in equity." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993). In *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 214 (2002) and *Sereboff*, 547 U.S. at 364-65, this Court explained that a reimbursement provision contained in the benefit plan gives rise to an "equitable lien by agreement" that attaches as soon as the funds from which reimbursement is sought are in the participant's possession. However, as both the Ninth Circuit in *Bilyeu* and Petitioner have pointed out, under *Knudson* and *Sereboff*, an equitable lien by agreement cannot be enforced against dissipated funds. *Bilyeu*, 683 F.3d at 1094-97; Pet. Br. at 23-29. Thus, this Court's precedents suggest the absence of a remedy where an ERISA fiduciary seeks to enforce a reimbursement provision over funds that have been dissipated.

B. 42 U.S.C. § 407(a) Precludes Assignment of Social Security Disability Benefits

Section 207 of the Social Security Act, 42 U.S.C. § 407(a), presents yet another obstacle for disability plans seeking to recover Social Security disability overpayments. That provision states:

> The right of any person to any future payment under this subchapter shall not be transferable or assignable, at law

> or in equity, and none of the moneys paid or payable or rights existing under this subchapter shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

The purpose of § 407 is to protect Social Security beneficiaries from creditors' claims. *Mason v. Sybinski*, 280 F.3d 788, 793 (7th Cir. 2002); *Dionne v. Bouley*, 757 F.2d 1344, 1355 (1st Cir. 1985). In *Philpott v. Essex County Welfare Board*, 409 U.S. 413, 415-16 (1973), this Court ruled that § 407 barred an attempt by a New Jersey governmental agency to attach retroactive Social Security payments deposited into the petitioner's bank account, despite the fact that the petitioner had previously signed a reimbursement agreement in order to receive interim state welfare benefits while his application for the federal benefits was pending. Similarly, in *Bennett v. Arkansas*, 485 U.S. 395 (1988), this Court ruled that § 407 preempted a state statute that permitted seizure of prisoners' Social Security benefits, observing that § 407 manifests the "clear intent of Congress that Social Security benefits not be attachable."

Importantly, *Philpott* held that although the benefits had been deposited into a bank account that was not specifically designated exclusively for Social Security benefits, the funds nevertheless retained the quality of "moneys" within the purview of § 407. 409 U.S. at 416. Subsequent courts have similarly treated an unsegregated bank account as

"consist[ing] of Social Security benefits," thus precluding attachment of the entire account. *See Dionne*, 757 F.2d at 1346 (ruling that post-judgment attachment of plaintiff's bank account, which consisted in part of Social Security funds, was improper).

In the ERISA context, courts have recognized that § 407(a) prohibits ERISA plan administrators from imposing a lien directly on Social Security benefits. *See, e.g., Bilyeu*, 683 F.3d at 1093-94 ("Under the Social Security Act, Bilyeu could not assign her social security benefits, and Unum could not attach them."); *Weitzenkamp v. Unum Life Ins. Co. of Am.*, 661 F.3d 323, 332 (7th Cir. 2011) ("Unum cannot impose a lien directly on Weitzenkamp's social security benefits."); *Epolito v. Prudential Ins. Co. of Am.*, 737 F Supp. 2d 1364, 1383 (M.D. Fla. 2010) ("To the extent Prudential seeks to recover the overpaid benefits resulting from Epolito's receipt of retroactive SSD benefits by imposing an equitable lien on the SSD benefits themselves, such a claim is barred by 42 U.S.C. § 407(a)."); *Mote v. Aetna Life Ins. Co.*, 435 F. Supp. 2d 827, 830 (N.D. Ill. 2006) (ruling that ERISA action to recover overpaid long-term disability benefits in an amount identical to the claimant's Social Security award was barred by § 407(a)); *Ross v. Pa. Mfrs. Ass'n Ins. Co.*, No. 1:05-0561, 2006 U.S. Dist. LEXIS 33875, at *22-23 (S.D. W. Va. May 22, 2006) (declining to impose constructive trust over future Social Security payments).

C. To Evade 42 U.S.C. § 407(a), Disability Plans Seeking to Recover Social Security Benefits Must Instead Impose Liens on Overpaid Long-Term Disability Benefits, But That Approach Is Problematic

To circumvent § 407(a), disability plans seeking to recover Social Security disability benefits instead assert that their lien is over the disability benefits that had previously been paid rather than the benefits resulting from the Social Security award. That practice was condoned without much discussion in both *Cusson v. Liberty Life Assurance Company*, 592 F.3d 215, 232 (1st Cir. 2010) and *Weitzenkamp v. Unum Life Insurance Company of America*, 661 F.3d at 332. Those authorities both remarked that § 407(a) did not bar an insurer from recovering overpaid long-term disability benefits, even though the amount of the alleged overpayment was identical to the retroactive Social Security payment.[10]

However, the Ninth Circuit exposed the underlying problem with that rationale in *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d

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[10] The distinction between Social Security benefits and overpaid long-term disability benefits was also ignored by the Third Circuit in *Funk v. CIGNA Group Ins.*, 648 F.3d at 194-95, which failed even to acknowledge the statutory bar imposed by § 207 of the Social Security Act and remarked, "Because the Plan and Reimbursement Agreements at issue here likewise specify the receipt of Social Security benefits as the particular fund from which reimbursement is to be made, they give rise to an equitable lien by agreement over those Social Security funds that are overpayments under the Plan."

at 1093-94. *Bilyeu* noted that unlike the third-party tort recovery in *Sereboff* or the contingent fee in *Barnes* v. *Alexander*, 232 U.S. 117, 121 (1914) (cited favorably in *Sereboff*), "the overpaid disability benefits are not a particular *fund*, but a specific amount of money encompassed *within* a particular fund -- the long-term disability benefits Unum paid to Bilyeu." *Id.* at 1093 (citing *Sereboff*, 547 U.S. at 364). Unum could have avoided that problem had it asserted a lien on the Social Security benefits themselves, but such an action was foreclosed by § 407(a).

Furthermore, the Ninth Circuit noted that the funds were no longer in Bilyeu's "possession or control" because she had spent them. *Id.* at 1094 (citing *Sereboff*, 547 U.S. at 363). The Ninth Circuit suggested that other courts, which had interpreted *Sereboff* as eliminating the requirement of strict tracing requirement once an equitable lien has attached to a particular fund, were mistaken, observing:

> The tracing issue in *Sereboff* was whether Mid Atlantic could obtain an equitable lien against specifically identified funds when Mid Atlantic had never possessed those funds itself -- an issue that has no relevance here. *See Sereboff, 547 U.S. at 364-65.* Nothing in *Sereboff* suggests that a fiduciary can enforce an equitable lien against a beneficiary's *general assets* when specifically identified funds are no longer in a beneficiary's possession.

Bilyeu, 683 F.3d at 1095. Other courts have similarly declined to extend *Sereboff*'s discussion of tracing rules to suits by a fiduciary to impose a lien over dissipated funds. *See Epolito*, 737 F. Supp. 2d at 1381 (collecting cases).

From a practical standpoint, the fact remains that the liens at issue in cases where insurers' reimbursement rights were recognized as stating claims pursuant to 29 U.S.C. § 1132(a)(3) are impermissible liens over Social Security benefits. The typical disability claimant is already reduced to living on a percentage of her prior income (typically 60 percent); unless the disability benefit beneficiary possesses independent financial means, disability benefits are used to pay for the necessities of life – food, clothing, and shelter. The notion that the disability benefits would remain in a beneficiary's bank account is highly unlikely, as acknowledged in *Mote*, 435 F Supp. 2d at 830. In response to an insurer's argument that it sought to impose a lien not on the claimant's Social Security benefits but rather on the overpaid long-term disability benefits, the court remarked: "That's obviously just not so -- instead the funds on which defendants seek to impose an equitable lien are exactly the same funds that the law labels and treats as Social Security funds that are taken out of reach by Section 407(a)." *Id.* By recognizing that an equitable lien by agreement cannot be imposed on funds that are no longer in existence (other than in situations where claimants attempted to defraud the benefit plans)[11],

[11] Plan administrators may still pursue a state law claim for fraud or intentional interference with contract against a

the protections of both ERISA and Social Security Act will be preserved.

II. The Eighth and Ninth Circuits' Approach Does Not Unduly Burden Disability Insurance Plans and Is Consistent with Congressional Intent

This Court should adopt the view of the Eighth and Ninth Circuits and rule that an equitable lien by agreement is unenforceable under ERISA § 502(a)(3) where the underlying assets to which the lien attached have been dissipated or are otherwise untraceable. The practical effect of such a rule on long term disability benefits will be minimal, since insurers retain the right to recoup overpaid long-term disability benefits by garnishing future benefits. Moreover, since the Social Security Administration utilizes a more stringent definition of disability than most disability insurance companies, the percentage of claimants whose disability benefits are terminated prior to a Social Security award will be small. And when that situation does occur, as this Court recognized in *Glenn*, 554 U.S. at 118, the circumstances are often suspect.

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claimant where the circumstances suggest that the claimant willfully dissipated funds or withheld material information. *See, e.g., Trs. of the AFTRA Health Fund v. Biondi*, 303 F.3d 765 (7th Cir. 2002) (ruling ERISA did not preempt action by plan for fraud where plan participant concealed his marital status); *Health Cost Controls v. Bode*, No. 93 C 3557, 1994 U.S. Dist. LEXIS 7820 (N.D. Ill. June 8, 1994) (ruling that attorney tortiously interfered with contract between an ERISA plan and plan participant by intentionally distributing settlement proceeds that were subject plan's lien).

In accord with *Glenn*, courts consistently have ruled that a termination of benefits, notwithstanding a Social Security award, is arbitrary and capricious. *See, e.g., Raybourne v. Cigna Life Ins. Co. of New York*, 700 F.3d 1076, 1087 (7th Cir. 2012); *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 679 (9th Cir. 2011); *Connor v. Sedgwick Claims Mgmt. Servs., Inc.*, 796 F. Supp. 2d 568, 585 (D.N.J. 2011). Two leading disability insurers, along with their subsidiary underwriting companies, have agreed to give deference to the Social Security Administrations findings of disability following market conduct investigations into their claims practices. *See* http://www.maine.gov/pfr/insurance/Admin_Enforcement_Actions/RSA_2013/CIGNA_RSA.pdf; https://maine.gov/pfr/insurance/unum/ UNUM_Regulatory_Settlement_Agreement.htm; *see generally* John Langbein, "Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA," 101 Nw. U. L. Rev. 1315 (2007).

The rule advanced by the Eighth and Ninth Circuits strikes the correct balance between containing plan costs and also protecting ERISA plan participants from the overly harsh consequences that too often result from insurance companies' reimbursement practices. The rule advanced by the Eighth and Ninth Circuits is also consistent with Congress's intent in enacting ERISA, which speaks of protecting the interests of plan participants and beneficiaries, not those of plan sponsors. 29 U.S.C. § 1001(a). ERISA treats plan sponsors as trustees and imposes upon them fiduciary duties of loyalty and care. *See* 29 U.S.C.

§ 1104. In *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1880 (2011), this Court observed that courts of equity routinely awarded make-whole relief to victims of a breach of trust. However, this Court has declined to interpret "other appropriate equitable relief" within the meaning of 29 U.S.C. § 1132(a)(3) to encompass "whatever relief a common-law court of equity could provide," since such an interpretation "would limit the relief not at all." *Mertens*, 508 U.S. at 257. Consequently, in *Knudson*, this Court declined to permit an ERISA fiduciary to enforce an equitable lien by agreement against a claimant's general assets, even though doing so left the plan without a remedy. 534 U.S. at 214.

Here, too, this Court should decline to enforce a welfare benefit plan's equitable lien where the assets to which the lien purports to attach have been expended for necessary living expenses and not to defraud a creditor, and where the only available assets to satisfy the claim are Social Security benefits which are protected from creditors pursuant to 42 U.S.C. § 407(a). Although such a rule may leave plan sponsors without a remedy in rare instances, that is precisely the balance Congress struck when it enacted ERISA. In the disability benefits context, the view presented by Petitioner, consistent with the approach adopted by the Eighth and Ninth Circuits, furthers ERISA's purpose by ensuring that plan participants are protected from lawsuits by unprincipled insurance companies, who would terminate disability benefits even in the face of a Social Security award; it also acknowledges Congress' paternalistic protection of Social Security

benefits against liens, garnishment, and other forms of attachment.

CONCLUSION

For the foregoing reasons, United Policyholders urges the Court to reverse the decision of the Eleventh Circuit Court of Appeals.

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